Florida International University
FIU Digital Commons

FIU Electronic Theses and Dissertations | University Graduate School

7-10-2000

# Facing a paradigm shift in professional credentialing: preparedness of registered dietitians for professional development 2001

Nancy Collins
*Florida International University*

**DOI:** 10.25148/etd.FI14060879
Follow this and additional works at: https://digitalcommons.fiu.edu/etd

 Part of the Dietetics and Clinical Nutrition Commons

Recommended Citation
Collins, Nancy, "Facing a paradigm shift in professional credentialing: preparedness of registered dietitians for professional development 2001" (2000). *FIU Electronic Theses and Dissertations*. 2411.
https://digitalcommons.fiu.edu/etd/2411

This work is brought to you for free and open access by the University Graduate School at FIU Digital Commons. It has been accepted for inclusion in FIU Electronic Theses and Dissertations by an authorized administrator of FIU Digital Commons. For more information, please contact dcc@fiu.edu.

FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

# FACING A PARADIGM SHIFT IN PROFESSIONAL CREDENTIALING: PREPAREDNESS OF REGISTERED DIETITIANS FOR *PROFESSIONAL DEVELOPMENT 2001*

A dissertation submitted in partial fulfillment of the

requirements for the degree of

DOCTOR OF PHILOSOPHY

in

DIETETICS AND NUTRITION

by

Nancy Collins

2000

To: Dean Ronald M. Berkman
College of Health and Urban Affairs

This dissertation, written by Nancy Collins, and entitled Facing a Paradigm Shift in Professional Credentialing: Preparedness of Registered Dietitians for *Professional Development 2001*, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this dissertation and recommend that it be approved.

Fatma G. Huffman

Ralph Lewis

Susan P. Himburg, Co-Major Professor

Dian O. Weddle, Co-Major Professor

Date of Defense: July 10, 2000

The dissertation of Nancy Collins is approved.

Dean Ronald M. Berkman
College of Health and Urban Affairs

Dean Richard L. Campbell
Division of Graduate Studies

Florida International University, 2000

©COPYRIGHT 2000 by Nancy Collins

All rights reserved.

# ACKNOWLEDGMENTS

I wish to thank the members of my committee, Dr. Fatma G. Huffman and Dr. Ralph Lewis, for their helpful comments and patience. A special thanks goes to my co-major-professors, Dr. Susan P. Himburg and Dr. Dian O. Weddle, for their endless support and encouragement.

ABSTRACT OF THE DISSERTATION

FACING A PARADIGM SHIFT IN PROFESSIONAL CREDENTIALING:

PREPAREDNESS OF REGISTERED DIETITIANS FOR

*PROFESSIONAL DEVELOPMENT 2001*

by

Nancy Collins

Florida International University, 2000

Miami, Florida

Professor Susan P. Himburg, Co-Major Professor

Professor Dian O. Weddle, Co-Major Professor

In the year 2001, the Commission on Dietetic Registration (CDR) will begin a new process of recertifying Registered Dietitians (RD) using a self-directed lifelong learning portfolio model. The model, entitled *Professional Development 2001* (*PD 2001*), is designed to increase competency through targeted learning. This portfolio consists of five steps: reflection, learning needs assessment, formulation of a learning plan, maintenance of a learning log, and evaluation of the learning plan. By targeting learning, *PD 2001* is predicted to foster more up-to-date practitioners than the current method that requires only a quantity of continuing education hours. This is the first major change in the credentialing system since 1975. The success or failure of the new system will impact the future of approximately 60,000 practitioners. The purpose of this study was to determine the readiness of RDs to change to the new system. Since the model is

dependent on setting goals and developing learning plans, this study examined the methods dietitians use to determine their five-year goals and direction in practice. It also determined RD's attitudes towards *PD 2001* and identified some of the factors that influenced their beliefs. A dual methodological design using focus groups and questionnaires was utilized. Sixteen focus groups were held during state dietetic association meetings. Demographic data was collected on the 132 registered dietitians who participated in the focus groups using a self-administered questionnaire. The audiotaped sessions were transcribed into 643 pages of text and analyzed using Non-numerical Unstructured Data - Indexing Searching and Theorizing (NUD*IST version 4). Thirty-four of the 132 participants (26%) had formal five-year goals. Fifty-four participants (41%) performed annual self-assessments. In general, dietitians did not currently have professional goals nor conduct self-assessments and they claimed they did not have the skills or confidence to perform these tasks. Major barriers to successful implementation of *PD 2001* are uncertainty, misinterpretation, and misinformation about the process and purpose, which in turn contribute to negative impressions. Renewed vigor to provide a positive, accurate message along with presenting goal-setting strategies will be necessary for better acceptance of this professional development process.

TABLE OF CONTENTS

LIST OF TABLES

# CHAPTER I

# INTRODUCTION

The link between food, nutrition and good health has become well accepted over the past three decades. Information that was once considered "good advice" handed out by home economists has evolved into the science-based practice of dietetics which ranges from medical nutrition therapy to treat disease to the cost-effective, safe management of foodservice operations. Registered Dietitians (RD) are the credentialed food and nutrition experts responsible for interpreting and disseminating this information. Registered Dietitians are charged with the mission of improving and protecting the nutritional health and well-being of the public in a variety of settings that includes hospitals, nursing homes, schools, governmental food programs, doctor's office, commercial foodservice operations, and many others. The job of the RD is to act as a member of the foodservice and healthcare teams and provide the services of a nutrition counselor, an educator, an information resource person, a foodservice manager, and a clinician with specialized expertise.

In as short a time as the past ten years, the healthcare delivery system has undergone a revolution at least partially related to cost-containment. The continuum of healthcare settings has expanded to include entirely new stages in care such as sub-acute and transitional care. The payment system for inpatient long-term care facilities has changed from retrospective to prospective. Patients are sicker and living longer. In the foodservice arena, the advent of new food technology and new food safety systems has made these areas more technologically advanced. All of these changes have in turn impacted the dietetics profession. With words such as multi-skilling now in vogue, healthcare professionals including dietetic practitioners are performing a wider variety of tasks in countless settings. Multi-skilling seeks to broaden jobs by cross-training a

person to do more than one function (1). Multi-skilling has led to broader job descriptions for dietitians. This means that practitioners may be doing work that has not been thought of as the traditional work of a dietitian or dietetic technician. For example, clinical dietitians in acute care may now find themselves taking blood pressure readings, inserting nasogastric feeding tubes, or checking blood sugar levels with fingerstick tests.

The impact of this change on dietetic continuing education and credentialing is that it is more difficult to determine what qualifies as necessary learning for each individual practitioner and how best to achieve this necessary learning. Today, the job of a dietitian cannot be easily defined by a list of job requirements nor can a credentialing body determine the educational needs of every dietitian. The extremely varied work situations of over 60,000 practitioners makes it difficult for the Commission on Dietetic Registration (CDR), the credentialing organization of the American Dietetic Association (ADA), to carry out its mission. The mission of CDR is to protect the nutritional health and welfare of the public by establishing and enforcing certification and recertification standards for the dietetics profession. These changes in healthcare delivery and RD job duties come at a time when the regulatory bodies, such as the Joint Commission on the Accreditation of Heath Care Organizations (JCAHO), are placing greater emphasis on competency and outcomes measurement. According to Dahl and Leonberg (2), JCAHO regulations potentially affects employers of approximately 65 percent of dietetics professionals.

For each credentialed RD, this changing environment means that he or she must find ways to keep current and keep his or her skills up-to-date. The rapidity with which nutrition information is being discovered, coupled with the advances in medicine, is staggering. There is the potential for unsafe and out-of-date practice unless the credentialing process assures a safe practitioner by requiring continuing education. It would be easy to let the speed of the medical revolution overpower the profession but to

assure a future for RDs, there must be evaluation and updating of the credentialing process. The ultimate question facing all medical credentialing agencies, not only CDR, is how to assure that the public receives the very best care based on the most current information. It follows that if a practitioner is going to represent him or herself as a credentialed RD, that credential must signify a unique expertise and become a trusted trademark to the public. In order to be of any value, the RD credential must be a reliable designation to state unequivocally that a practitioner is current, well versed, and dependable as a source of food and nutrition information. Registered Dietitians must be trusted by the public to provide safe food and nutrition interventions and to be practicing within accepted guidelines. If the RD credential does not carry this weight, the credential becomes meaningless to both the general public and the practitioner.

This means that there must be a regulated system to assure that practitioners continue to grow and develop well beyond their college graduation. Learning needs must be continually evaluated and corrective action taken if the RD credential is going to thrive in the future. Although it seems obvious that learning must continue, the demands of modern life may eclipse the time needed to actually fulfill this goal. Theory and reality diverge when family responsibilities, financial constraints, day-to-day job demands and a host of other situations are added to the equation. So how does a credentialing body overseeing approximately 60,000 individuals working in literally dozens of job settings assure that each person is striving to be the best and safest practitioner that he or she can be?

In order to accomplish its mission, CDR has proposed a plan of responsible life-long learning. The CDR is the one of the first professional credentialing bodies to adopt a lifelong learning plan and will be closely watched by other health professions. The new plan, called *Professional Development 2001* (*PD 2001*), requires that every credentialed individual devise and execute a self-designed five year learning plan. The *PD 2001*

model consists of five steps. The first step of this plan is reflection. Reflection is defined as reviewing, reenacting, and analyzing one's performance and grounding explanation in evidence (3). For a dietetic practitioner, reflection will also serve as a time to reflect upon practice and consider goals for both the short and long-term. Without reflection, there is no direction for continuing education since goals may not be clearly defined. By requiring reflection, a dietetic practitioner will have a prescribed time to think about the future career path he or she will embark on. Reflection sets the stage for Step 2, Learning Needs Assessment. This self-assessment step will serve to elucidate the gaps between the current proficiency level of practice and the desired proficiency level of practice. Although entry level practice skills may be similar throughout the field, advanced practice skills may be substantially different among practitioners necessitating a different body of knowledge from one person to another. Each practitioner will be called on to decide what learning is necessary for him or her to perform at a competent and responsible level. Once these two steps have been completed, the practitioner can formulate a learning plan. The learning plan will summarize the findings of the two previous steps and define a method of continuing education. Once this step is reached, the practitioner will be self-responsible for continuing education activities that will help her or him meet the goals of the learning plan. These activities will be kept on a learning log. The final step of the process is the evaluation of the learning plan and the transfer of learning into practice. By evaluating this transfer, *PD 2001* becomes remedial and instructive for the credentialed practitioner.

This method purports to foster growth and refinement in both methods of goal setting and educational activities attended. Since the educational activities will be targeted to specific learning needs, a parallel benefit of the new system may be to increase the quality of continuing education programs as practitioner demand for efficient and effective courses of study increases. The practitioner will be able to target learning to

actual needs rather than randomly attend educational events only to find that they had no relevance to practice.

These five steps taken together meet the objectives of both the changing healthcare environment and CDR. The main objective is to credential dietitians who are up-to-date and meet the knowledge requirements of their individual work situation. By targeting learning, the *PD 2001* method is predicted to meet these goals better than the current method of credentialing which only requires a quantity of CE hours that is not targeted to learning needs. *Professional Development 2001* promotes life-long learning by requiring practitioners to continually work through this cycle of development. Advances in medical nutrition therapy and medical technology dictate that practitioners continue learning even after they have graduated from the traditional educational setting. As fundamental changes in medical education and certification are researched, it is being discovered that the finite period during which basic education is taught has very little acceptable rationale (4). This implies that there is very little reason, other than custom, for determining the length of formal education and that education must continue.

The CDR selected lifelong learning using a portfolio method as a means of advancing dietitians into the next millennium and to assist in ensuring the competency of practitioners. The CDR will administer this system with all practitioners required to submit forms at both the beginning and end of their certification period. The CDR is currently monitoring all Continuing Professional Education (CPE) activities and has designed this system to be administratively manageable. Since the Standards of Professional Practice and the Code of Ethics for the Profession of Dietetics will guide the process, it will meet the goal of accountability with revocation or suspension of the right to use the professional credential as the primary method of enforcement.

The *PD 2001* credentialing system will be phased in over a five-year period with approximately one-fifth of all credentialed individuals affected each year. Only those

practitioners whose credential expires in 2001 will be affected the first year. This phased implementation system will continue until the year 2006 when all dietitians will have developed lifelong learning plans using the *PD 2001* method.

When CDR implements this system in 2001 it will become the example and model for other healthcare credentialing bodies. The success or failure of this system will forever impact the profession of dietetics. In addition, as dietetics sets higher standards for professional credentialing, other medical professions will have an interest in the outcome. A successful implementation may mean that CDR sets new standards for credentialing agencies certifying doctors, dentists, physical therapists, and possibly countless others. Public failure may spell doom for over 60,000 individuals who depend on the RD credential to earn a living. The success or failure of this plan will also affect the viability of the American Dietetic Association (ADA) as a professional association. It is essential to study the implementation to determine if RDs are ready and willing to make the paradigm shift to self-monitored continuing education. Are they prepared to tackle the challenges that this new system portends? Are they capable of meeting the requirements? Do they possess the necessary skills? Is the attitude towards the new system positive and welcoming? As these questions are answered in advance of the implementation, the results can be used to improve the process and create more successful outcomes. This type of major overhaul to a credentialing system occurs infrequently. The research environment created at this point in time is unique and one that should be studied vigorously and in a timely fashion. This research project investigated the readiness of the RD community for the big changes ahead and provided valuable insight regarding the attitudes towards *PD 2001*.

# CHAPTER II

# LITERATURE REVIEW

In order for dietitians to assure and maximize their roles on the healthcare teams of the twenty-first century, they must be well prepared for the future and adaptable to change. The Registered Dietitian (RD) credential must be synonymous with competence for the well-being of both the patient and the healthcare institution. One goal of credentialing is to protect the public. For example, professional use of a credential such as RD, is often used by the public as a means to separate qualified individuals from the non-qualified or charlatans. The qualified practitioners present science-based accurate information that is fair and balanced and presents the pros and cons of various treatments. Charlatans are often selling products and do not promote accurate science-based information. The use of the RD credential is intended to imply a minimum level of competence including up-to-date knowledge no matter when the formal education period ended.

The JCAHO has placed an increased emphasis on staff competence. Over the past several decades there has been a decline in the public's trust in the competence of healthcare providers. According to Inman-Felton and Rops (5), consumers no longer take the word of a healthcare provider as absolute truth. Proof of competency is demanded and skepticism is wide-spread. This implies that not all healthcare providers are equal and that consumers must choose practitioners with care.

## History of the Credentialing Process for the Registered Dietitian

In order to understand how dietitians will prepare for future challenges, it is important to understand the basis of the RD credential from the beginning. Before a profession can certify the competence of a practitioner, it needs to be clear as to practice roles (6). This meant that before dietitians could be registered, it was necessary to decide on the knowledge and performance requirements of an entry-level practitioner. These educational requirements continue to be refined periodically to reflect the desired current

knowledge of dietitians. In addition, the requirements must assure that practitioners provide accurate and safe information and treatments.

The title "dietitian" was coined at the Lake Placid Home Economics Conference in 1899, meaning "a person who specializes in the knowledge of food and can meet the demands of the medical profession for diet therapy" (7). Before this, practitioners were called dietologists, dietists, and dietotherapists. In 1969, registration of the dietitian became effective. Registration provided a legally protected title for credentialed practitioners. Registration required membership in the American Dietetic Association and an examination. At this point in time, a minimum level of competence was established in order to be granted the use of this protected title. Once credentialed, the practitioner had to meet continuing education requirements. Continuing education was thought of as a means of disseminating information and for providing professional growth opportunities. This definition still applies today. In November 1975, CDR was made an independent unit of ADA and given responsibility for all aspects of the registration process including deciding the process for credentialing and recertification (6). The members of CDR are elected by the general membership of the ADA.

The practice of dietetics has three components: 1) nutrition and food services in health and disease, 2) management of food and other resources, and 3) education of patients/clients, the public, students, and other healthcare professionals. The very first dietitians were expected to perform all these tasks (8). Today, there are different levels of nutrition professionals such as the Certified Dietary Manager (CDM) and the Registered Dietetic Technician who perform the more routine tasks. Certified Dietary Managers usually are certified through a correspondence course from a variety of institutions. Registered Dietetic Technicians are under the jurisdiction of CDR. At advanced levels of practice, each dietitian has a unique work situation and may have vastly different job duties than dietitians in years past.

**What Are Credentials?**

There are at least four major types of credentials widely used in healthcare. These are licensure, certification, accreditation, and specialized credentials. According to Stromberg (9), licensure means that the state government has granted an individual permission to engage in an occupation. This definition holds true for the profession of dietetics, which is licensed by individual state governments. Currently, 39 states plus the District of Columbia regulate dietetic practice (10). Licensure is based on a judgment that the applicant has the minimal degree of competence necessary to protect the public health, safety, and well-being. Stromberg (9) continues to define certification as meaning that a governmental or non-governmental association has granted to an individual, who has met certain qualifications, the right to use a specialized occupational title. Under these laws, non-certified individuals are not prohibited from practicing the occupation, but they may not use the particular professional title. While licensure and certification apply to individuals, accreditation is a process for recognition of educational institutions or facilities. Accreditation is based on standards generally thought to be correlated with high quality services. The final category defined by Stromberg (9) is specialized credentials. These may be given by healthcare providers and may take the form of certificates of competence in a particular technique, fellowship in a professional organization or academic credentials.

It is important to understand the different type of credentials in order to understand the governance and requirements of each. The credential that CDR regulates falls under the certification category. The CDR is a non-governmental body that permits individuals to use the term Registered Dietitian and the letters RD if educational and experiential requirements are met. Individuals who do not meet the requirements may not use this designation. One of the requirements for maintenance of this certification is continuing education.

**Continuing Education in Health Fields**

Continuing education (CE) has been an integral part of credentialing in many fields. Continuing education is a vital component in keeping the practitioner apprised of contemporary health issues and research methods (11). It is estimated that the half-life of dietetics education is about three years (12). This implies that dietitians must engage in productive and meaningful continuing education if they are to be current. This leads to a discussion of how a practitioner in any discipline determines what his/her continuing education needs are and the best way to meet those needs. Should this be determined by the individual or by the professional credentialing body?

Public Health Nurses have been faced with a similar situation to dietitians. The nurses work in many different sectors within the community with each area having its own job requirements. This is quite similar to dietitians who also work in varied settings with unique knowledge needs. Nursing researchers conducted a study to determine the continuing education needs of their field (13). It was discovered that the knowledge and skills needed for public health nursing practice were growing more complex. Clients coming to public health settings were more ill than in the past and in need of more services. The nurses participating in the study identified 89 different topics when asked to list their CE needs. After analyzing the topics, the researchers divided the topics into three content areas. The first area was specific disease topics such as diabetes, pediatrics, AIDS as well as genetic disorders. The second area was management skills including budget and communications. The final area was Public Health Nursing content including health assessment, nursing process and theory, communicable disease control, and epidemiology. The conclusion was that lifelong CE is necessary to meet the public's changing healthcare needs and that the future of Public Health Nursing depends on the educational competencies and technical skills that the practitioners demonstrate (13).

This study is remarkable in its parallels to the dietetics profession. In a 1997 commentary, Puckett (14) reported that after interviewing 33 dietetics practitioners, thirty respondents agreed that dietetics education was not keeping pace with the changes in the healthcare industry. This essentially mimics what was found by the Public Health Nurses. The commentary concludes that formal undergraduate education must be augmented with the view that education is a life-long learning process. Each practitioner needs to adopt a lifelong habit of continuing education in order to be a valuable member and contribute a particular skill to the interdisciplinary team. Again, this drive for competent, useful practitioners is reiterated as a means to insure the discipline a place on the healthcare team of the future as well as a means to protect the public.

Pharmacists have also grappled with the issue of continuing education requirements. To date, 48 state pharmacy boards require CE for renewal of a license (15). Of these 48, 10 require the CE in specific topic areas. Although this is still a small number of the total, it is implied that there is a trend toward targeted CE as new areas of medicine unfold. For example, the number of HIV and AIDS pharmaceuticals has increased dramatically and this is one topic that has been specifically required in certain states in order to obtain a license.

A similar situation has occurred the field of health sciences librarians. The rapid rate of growth and change in the biomedical and information technology knowledge bases has placed a great burden on health sciences librarians to develop a strategy for continuous learning. The job of a librarian is to locate and help disseminate new information and the developments in computers and electronic information has vastly changed the methods for accomplishing this task. The profession, like dietetics, has been faced with how to assure that each professional in the field is up-to-date and proficient in the current technology. A study published by Brandt, Sapp, and Campbell (16) describes a pilot study that utilized different technological delivery methods to get the information to the

librarians. These delivery methods included a telecourse, via the World Wide Web, and an electronic poster session. The relevant conclusion was continuing education must be timely and accessible regardless of the librarians physical location. In order to meet these goals, continuing education programs may have to be offered in new forms that utilize today's technology. This applies to dietitians as well who may not even be familiar with the technology and would have to learn that first.

Gynecological physicians have also faced this continuing education question. Gates (17) believes that there must be a balance between keeping gynecologists up-to-date in new surgical techniques while providing competent care for patients. New endoscopic procedures have been perfected that result in smaller incisions, decreased pain, and quicker recovery times. Quite often the press publishes the benefits of these techniques before physicians have been properly trained and have had the necessary time to learn these procedures. At the same time, the public demands the procedures because of the many benefits. This leaves the gynecological profession in a quandary about continuing education requirements. This is similar to dietitians who are called by consumers on all the latest news topics. Gates (17) supports peer review as a means for evaluating competency. She discusses that a significant portion of learning comes from more experienced surgeons showing other surgeons how to correctly perform the surgery. The more experienced surgeon then can evaluate the ability of the others. Peer review coupled with didactic education may help practitioners to stay current on new techniques. This study illustrates that other professions are examining the same issues as dietitians including how best to protect the public and insure professional competency.

**Lifelong Learning of the Health Practitioner**

Professional development is a lifelong process. Most adults do not sit down and plan exactly what and where and when they are going to learn. The process is more haphazard in nature and is often a series of trial-and-error occurrences (18). Many dietitians attend

monthly dietetic association meetings and receive CE credits for whatever the topic of the month happens to be even if it bears no relation to their current area of practice. If a professional is faced with many continuing education choices, how should the determination of which activities to include in career development be made?

It could be argued that learning begins at conception and continues throughout life. It is estimated that people develop approximately 50 percent of their ability to learn in the first four years of life (19). Complicating this matter is the lengthening of the number of career years which has increased as the lifespan increases. Learning can occur in formal or informal settings. According to Maslin-Prothero (19), the terms "lifelong learning" and "lifelong education" are used interchangeably but there is a small difference. Lifelong education is concerned with more formal approaches to learning and includes schools, colleges, universities, and those organizations involved in vocational training. Lifelong learning develops through primary and secondary socialization. Knapper and Cropley (20) define lifelong learning as a conscious activity that has definite goals that are the reason the learning is undertaken. The learner is intending to retain what has been learned for a considerable period of time.

According to Bronte (21), there are strong indications that the developmental pattern of a long lifetime is quite different from that of a short lifetime. In her Long Careers Study, voluntary participants from the general population generally showed three different career patterns. The Homesteaders stayed in the same career throughout their lifetime. The Transformers made one career change at some point in their life and the Explorers changed careers frequently. The defined pattern appears to hold relevance for most professions. This complicates the issue of continuing education since there will inevitably be people of all categories and ages in every profession. One type of continuing education requirement may not fit the entire group because each individual comes with his or her own learning needs. Quality then becomes an issue rather than

quantity. The current continuing education system for dietitians requires a quantity of continuing education hours (currently 75 hours per five-year credentialing cycle). The current system for prior approval of CE programs is to submit the program objectives, an outline, and the speaker's qualifications to CDR. The CDR then grants approval for the program if it is related to dietetics. There is no mechanism for evaluating the quality of the program once approval has been granted.

Queeney and English (22) provide a definition of quality to assist educators in evaluating educational programs. The first criteria they looked at was the participant's readiness to learn. It has been proposed by Dowd (23) that if we incorporate a design into continuing education that makes learners take responsibility for their own learning, they will voluntarily choose activities that will benefit them. This principle can be seen in the structure of *PD 2001* and provides the rationale for the new system. The second criteria for quality put forth by Queeney and English (22) was relevance to practice. Again, *PD 2001* encompasses this principle by directing dietitians to CE activities that they believe will be relevant to their needs. The 1995 Dietetics Practice Audit (24) conducted by CDR confirmed that dietitians work in a variety of settings and perform a wide variety of tasks. A successful CE plan must allow for participants to choose activities that are relevant to their practice area.

Houle (25) has identified three trends that have significantly changed the course of CE. First, many people are entering professions later than at the traditional times. Second, many people are switching careers and having second careers. Finally, the avid desire to learn may make its appearance somewhat later than traditionalists have assumed. Houle (25) believes that the pattern of learning of an individual is always unique and that individuals have many shifts during the lifetime of practice.

Affara (26) has identified trends that influence healthcare and are reflected in the lifelong learning patterns of nurses. One trend cited is the mastering of information and

communication technologies. The next generation of healthcare workers will be practicing in a very different environment. Affara (26) holds that future healthcare workers must be able to use sophisticated information and communications technology such as telemedicine and telenursing. The current focus of healthcare systems is cost containment, flexibility, and multi-skilling. Healthcare is becoming more community based as hospitals partner with communities and move to outpatient care and lifelong learning of health professionals must meet these trends.

Verma and Singh (27) state that the concept of education has undergone tremendous change over the past decade. The major change has been a shift to learner-centered learning. Under this system, education is no longer to impart a few facts and figures over a period of time but rather to arm the learner with strategies and concepts to continue lifelong learning. Much of medical education is still teacher-centered and the graduates may be at a loss once they leave school and that this may have a negative effect on patients. Since healthcare requires workers to acquire new skills and knowledge as new developments occur, it is very appropriate to rely on CE. In fact, there is a vital link between effective CE and successful implementation of health programs. It is believed that continuing education should play a part in improving quality of health services by enhancing skills and encouraging best use of limited resources (27). Continuing education should be aimed to stimulate and promote learning. It should facilitate access to relevant learning material.

Verma and Singh (27) described two continuing education strategies: "the cascade" and "the mushroom". The cascade begins at the top by creating a national body of knowledge which is then passed down through different levels of training programs. For example, research institutions may discover new knowledge and then through various educational seminars, they pass this information down to practitioners. The problems they cite with this approach are that the message gets diluted as it is passed downward

and that it is difficult to monitor the transfer of information once the training is completed. The mushroom strategy starts at the local level, in areas with strong leadership. This means that certain locales may be uncovering new methods of doing something and sharing this information with nearby colleagues. The information transfer is more haphazard than the linear path of information in the cascade. The mushroom strategy is designed to be flexible and to run with a low input of resources. The negative side of this strategy is that it may be difficult to maintain a high level of enthusiasm once the initial effect has worn off. It is useful to examine dietetic continuing education in relation to these two approaches. Traditionally, educational programs have taken the cascade approach where a national "expert" speaks at various meetings and disseminates information downward. Invited speakers who are well-known in their areas of nutrition give lectures at state and national meetings. The audience members listen to this information and then return to their workplaces. *Professional Development 2001* may foster the growth of the mushroom strategy as dietitians will have more flexibility to formulate programs that meet their particular needs and therefore, develop enthusiasm for sharing this information. For example, if a dietitian is studying nutrition for the cancer patient in accordance with an identified learning need, she or he may share that information with others who are nearby and have identified the same learning need.

**The Portfolio Model**

The credentialing agency of ADA has decided on a portfolio development model of recertification. The use of portfolios within the health professions is increasing as the complexity of what professionals are expected to do increase (28). A portfolio is defined by Jensen and Saylor (29) as a compilation of evidence that can be used to provide additional insight into educational experiences. The *PD 2001* method may be thought of as a portfolio involving reflection, self-assessment, and the formation of a learning plan.

The *PD 2001* Portfolio Guide (12) defines a portfolio as " a tool to guide and document professional development."

Jensen and Saylor's (29) study of portfolios involved graduate health professions students in the fields of nursing and physical therapy. The students were instructed to assemble a portfolio to deliberately evaluate their learning experiences in a university course. The portfolios could contain journal entries, examples of classroom work, papers, and anything that the students felt represented learning. Although the portfolios varied in structure, the students reported that the portfolios provided a formal way for looking at their progress across time. *Professional Development 2001*, utilizing a more structured portfolio with specific requirements, may produce the same result of showing growth over the five-year cycle.

A number of factors have contributed to the development of more flexible, self-directed approaches to learning. According to Maslin-Prothero (30) these include resource constraints, increasing demands on lecturers, downsizing of organizations, and new technologies. She discusses how lifelong learning affects the nursing profession. The healthcare environment is a dynamic one where the expectation is that the nurses can adapt to changing needs. This requires strong core skills and the right frame of mind where nurses can identify solutions and adapt to meet new challenges. Lifelong learning offers a way of enabling professionals to continue to develop. Maslin-Prothero (30) states that nurses need professional and academic role models. A philosophy and commitment to lifelong learning needs to pervade the professional organizations and it must acknowledge that learning can happen in many settings. Learners have a range of experiences that they bring to the learning and the various preferred learning styles of the learners must be met by providing choice, variety, and control over the learning activities. The philosophy of this article is mirrored in the *PD 2001* program. By allowing each dietitian the opportunity to define exactly what their own individual needs are and then

determine the best way to meet those needs, *PD 2001* recognizes the fact that compliance is best achieved when there is flexibility to meet the needs of a large and diverse group. *Professional Development 2001* assumes that dietitians possess the skills and have access to the reflection tools necessary to recognize their own needs. This may not hold true for all dietitians and may affect the success of *PD 2001*.

Tassone and Speechley (31) conducted a study with physical therapists to determine what factors influenced the therapist's participation in continuing education programs. This study was conducted in Ontario, Canada and sought to define differences in participation between rural and urban therapists. The researchers used a questionnaire and simple random sampling. The first part of the questionnaire contained closed-ended questions to elicit responses about program design preferences. The second and third parts of the questionnaire asked the therapists to rate their perceptions and preferences on learning methods using a seven point Likert scale. The results showed that the majority of respondents preferred full-day offerings held on Fridays or Saturdays in the fall or winter months. Physical therapists generally preferred a conference or workshop format, to have costs shared by their employer, to pay no more than $20 (Canadian currency) an hour, and to have practical instruction. Short travel distances was preferred if the employer did not share costs. The therapists in the more rural region were more interested in teleconferencing. Therapists in both regions rated content pertinent to current practice and courses available in their area of interest as the most important factors influencing participation in continuing education activities. If dietitians have the same preferences as the physical therapists in this study, five-year goals and learning plans may be adapted to fit the continuing education preferences. The providers of continuing education should know these preferences so programs can meet the desires of dietitians.

In the book *The Emergence of Learning Societies: Who Participates in Adult Learning?*, Belanger and Valdivielso (32) devote a full chapter to discussing the problem of lifelong learning in order for American workers to keep up with the responsibilities of their jobs. Like healthcare workers, almost every profession in the United States has been faced with the question of how to keep their employees current and well-skilled after the formal education period has ended. Belanger and Valdivielso define the attributes of continuing education activities in which workers participated in during the twelve-month period of their study. They state that the employer paid for the majority of activities and most utilized traditional, non-electronic delivery methods. These included classroom instruction, workshops, and conferences. They also define the most common barriers to participation as lack of money, too busy or lack of time, family responsibilities, and too busy at work.

Klevans and Parrett (33) sought to define the continuing education needs of Pennsylvanian dietitians. To do this, they first invited 22 clinical dietitians to participate in focus groups. The dietitians suggested continuing education topics in four aspects of practice. These included clinical, procedural, professional development, and management skills. The data from the focus groups was used to design a questionnaire that was distributed at the state annual meeting. They also used an electronic recording device as an alternate to the paper questionnaire during the meeting. In total, 94 responses were obtained during the meeting. The respondents favored live, affordable, conveniently located programs delivered by an expert using a participatory format. On the question of desired topics, the researchers noted that the data obtained emphasized the diverse interests of dietitians in practice. Topics ranged from clinical to management to

community and even non-nutrition topics. Work settings, current duties, future plans, and number of years of experience all appeared to influence their choice for topics. They conclude that continuing education should be based on both organizational and individual goals and needs and lead to a comprehensive plan for ongoing professional development. This study, although conducted before *PD 2001* was designed, mirrors much of the philosophy of *PD 2001*. It is remarkable that this small study demonstrated essentially the same findings of other researchers in that CE must be relevant, affordable, and meaningful in order to be useful to those in attendance.

The CDR has examined the economics of lifelong learning and portfolio development since money is known to be a barrier to participation in CE. The cost to the certified professional was a factor in determining the requirements of the portfolio (34). The CDR has revised the portfolio model in order to include a selection of assessment and recertification options that will result in no cost increase to the individual. A second economic issue that warrants consideration is the cost of administering *PD 2001*. The CDR believes the system is administratively manageable and will not result in increased costs over the current mandatory CE system (12). The third economic issue is the economic impact on the providers of CE programs. Local and state professional groups depend on CE programs for a significant portion of their annual income. The CDR plans to implement a system to assist the providers in planning targeted CE programs that will meet the learning needs of their members. However, according to Dahl (34), the portfolio method may have a negative economic impact on the providers of continuing education programs. Since there will be so many different topics and new ways to obtain

CE, such as mentoring, authoring a book, or obtaining an advanced degree, the providers of more traditional CE may not have as many clients.

Transfer of learning into practice is another concern. Does portfolio documentation of various CE activities actually make for a better-trained practitioner? A study was conducted in the field of health sciences librarians to answer this question. Von Reenan (35) states that total quality management (TQM) and continuous quality improvement (CQI) are among the major recent developments affecting health sciences librarians. Health sciences librarians rely on continuing education courses provided by their regional and national associations to keep up with current trends and developments. There have been many courses on TQM and CQI and von Reenan (35) sought to determine if these courses were adequate to meet the training needs of the librarians. He followed participants of a specific course that was offered three times throughout the study period. Course content was consistent for all three programs. Six months after the course, he sent a questionnaire to the participants. A group of thirty non-participants served as the control group. The results indicated that the knowledge goals were met but the behavioral change lagged behind. This may be because the course was a one-time program and there was no follow-up of transfer of learning into practice. The stated goal for attending the program for the majority of subjects was to gain a basic understanding of TQM and CQI. Six months later the participants did feel that they had gained the information they needed.

The behavioral goals at the onset of the program included using statistics, involving staff in TQM, and achieving increased influence and input into TQM issues in the organization. Six months after the CE program, these goals were not met. Von Reenan

(35) believes that professional organizations can maximize the effectiveness of CE programs by encouraging their members to take an active part in organizational program planning in order to design programs that are relevant. They suggest that there should be a continuum of courses and workshops over the course of several years that is paced according to industry-wide developments. A basic introductory course should be offered every year, while an additional level of training should be offered for those who need it. Instructors should provide participants with ideas and assignments for applying the principles learned back on the job. For example, preparation of "transfer action plans" during a program facilitates the transfer of newly acquired behaviors to another environment. These techniques are useful for any field including dietetics. The circle of learning will only be complete once there is a behavior change and practice has been improved. It is important for CE providers to understand the process of learning transfer in order to design programs that will help foster this step of learning.

**Models of Competency**

In July 1997, a Continuing Competency Summit was held in Chicago, Illinois. The Interprofessional Workgroup on Health Professions Regulation (IWHPR) sponsored this summit. Barnhill (36) presented two models of competency designed to facilitate evaluation of the assumptions made for different continuing competence components. Barnhill (36) calls his model the "Angels and Insects" model. They represent endpoints on a continuum. His model provides a framework to evaluate the responsibilities of some of the participants in the certification process. The Angels use the "trust me" philosophy or self-selected CE while the Insects have a "show me" philosophy. The demonstration may be a proctored recertification exam or prescribed CE requirements. The Angels

believe that all certificants are motivated and will do what is necessary to maintain competence. They believe that continuing competence is the responsibility of the professional. On the other hand, the Insects believe that most certificants are properly motivated but there may be a few who are not and therefore, the certificant and the certifying agency share a responsibility to ensure continuing competence. The Angels believe that the job of the certifying agency is to provide a structure that facilitates or "reminds" certificants to maintain competence. The Insects believe that the certifying agency must provide some assurance to the public that certificants maintain a minimum level of competence. The *PD 2001* program fits in to the Angel model. Barnhill (36) continues to describe how those who are less than competent are identified. Both models are quite similar on this point, as the major method of identification is failure to participate in the recertification process. Other methods include failure to pass a take-home or recertification test, disciplinary action by state boards, or malpractice awards. The advantage of the Angel model for the professional is minimal or no chance of losing the certification, less stress, and maximum flexibility in selecting CE activities. The Insect model does not offer these advantages. For those so inclined, the Angel model makes it fairly easy to simply complete the paperwork without participating in any CE activity. However, the advantages of the Insect model come for the public. In that model, the public is assured that at least once during the cycle, the certificant has demonstrated in a proctored exam, that he or she is at least minimally competent. The criticism of the repeated exam is how can a generalist examination realistically test a practitioner who has been in practice long enough to specialize? The Angel portion of this model describes the *PD 2001* model.

**Evaluating Competency**

It has been established that one of the goals of having a protected credential is to protect the public and assure a minimum level of competence (6). The self-directed portfolio method used in *PD 2001* leaves the evaluation of proficiency level up to each individual practitioner. Critics of *PD 2001* ask if self-evaluation is an adequate method for evaluating competency.

To answer this question, we can first look to JCAHO to determine how they evaluate competence. The JCAHO has established competence assessment and development standards to which facilities must comply in order to maintain accreditation. The JCAHO manual for accreditation outlines standards for all aspects of management of nutrition care processes. They define standards as a minimum level of performance for which organizations are evaluated (37). For example, one standard states "The leaders ensure the competence of all staff members is assessed, maintained, demonstrated, and improved continually." During an inspection, the inspectors evaluate compliance with this standard by examining policies and procedures, competency checklists, specialty certifications, customer and employee satisfaction surveys, performance measures and indicators, continuing education records, training records, and minutes from team meetings or performance improvement reports (38). Inman-Felton and Rops (38) state that the intent of this process is to have the leaders of each organization empower employees at all levels to take accountability for their job responsibilities. They maintain that leaders need to provide an environment that supports and motivates staff to continue to learn and develop new skills. This philosophy can also be seen in the structure of *PD 2001*. If employees are properly trained and given opportunities to improve and learn, they will do

so. The feedback mechanism in the system is criteria-based performance evaluation and customer, peer, and self-evaluations. Inman-Felton and Rops (38) are supporters of peer review and believe this is often an overlooked means to assess, maintain, and improve competence. A simple example in the dietetics profession is to have one clinical dietitian audit the charting of another. This can provide a means for improving documentation skills especially if the clinical staff has participated in developing the standards.

Other systems have been utilized to monitor competence in healthcare. The purpose of the Healthcare Quality Improvement Act (HCQIA) of 1986 was to establish a national reporting system intended to improve the ability of healthcare to police itself. The act's principal program, the National Practitioner Data Bank (NPDB) was designed to collect comprehensive data on malpractice and make this information available to credentialing authorities (39). For example, there had been cases of physicians being disciplined for malpractice in one state and then simply moving to another state and starting over. The NPDB sought to create a national list of malpractice actions so that impaired physicians could not geographically distance themselves from their records. The HCQIA calls for two types of actions to be reported to the NPDB. These are malpractice payments and adverse actions. Adverse actions fall into three classes as follows: 1) those taken against a practitioner's license by a state medical or dental board, 2) those taken against a practitioner's clinical privileges as a result of a professional review action, and 3) those taken against membership by a professional society. A total of 18,561 adverse actions were reported during the first year, 1990. A total of 6,482 queries resulted in disclosing information about a practitioner. There is no equivalent policing system in the field of dietetics. This reporting system may monitor incompetence but it does not take any steps

to insure competence. The question it raises is of the sufficiency of self-evaluation of competence. There are very few malpractice actions taken against dietitians so there is no equivalent measure from which to draw the final line between competence and incompetence. Self-evaluation in combination with performance reviews and peer evaluation appears to be a more motivating method to encourage professional development.

Perhaps the final evaluation of competency is determined in a court of law. Issues concerning health professionals' credentials have spawned hundreds of court cases according to Stromberg (40). He states that the courts' view of credentialing systems has changed in this century. Early in the 1900's, courts viewed the licensure of professionals as a technical matter to be supervised by the profession alone. By 1959, the United States Supreme Court was willing to limit boards' discretion by declaring that a standard or qualification for entry must have some rational connection to the person's fitness for the profession (40). By 1980, many courts had ruled that licensing applicants had to be afforded due process under fair standards. This means that the dietitian credential should be awarded only if the applicant has met the fair and published standards but on the other hand, these standards should be carried out with equality. The standards for certification must be clear enough to be understood by those subject to them and then uniformly enforced. The CDR portfolio method has not been tested in court yet since it won't be in effect until 2001 but has been developed with the specific aim of protecting the health and well-being of the public (41).

**Focus Groups**

Traditional research in scientific fields has been based on testing a hypothesis using parametric statistics. However, if the researcher is attempting to gather information on attitudes, opinions, or other emotions, it may be difficult using a traditional approach. Qualitative research provides an alternate means for collecting data that does not lend itself to a preconceived, testable hypothesis. When conducting qualitative research, the researcher enters the research situation without a prior hypothesis or expected outcome and rigorously collects data using varied methods. The hypothesis reveals itself through the data once it is analyzed.

One qualitative method of research is the focus group interview. Focus groups are a qualitative means of collecting rich and innovative data (42). This is a type of research that evaluates how people regard an experience, idea, or product by asking open-ended questions (43). In simpler terms, the focus group interview is an in-depth group interview on a particular topic that can be used to gather information on what participants think and why they think as they do (44). Focus groups are ideal when trying to get to the heart of emotions and belief systems.

The qualitative approach is much different than the quantitative approach. The qualitative method permits the researcher to interact with those in the study without a hypothesis formulated. This interaction may assume the form of living with or observing informants over a long period of time, or actual collaboration (45). Specifically, the focus group methodology consists of asking a fairly homogeneous group of seven to ten participants a series of open-ended questions (46, 47). During focus groups, the researcher uses probes to gain clarification of answers and to get further information.

Because the purpose in using focus groups is self-disclosure, homogeneity is seen as reducing perceived risk to the informants. Dietitians may be considered a homogeneous group because they are in the same profession even though they may be performing different day-to-day job duties.

The main advantage of a focus group interview is the opportunity to observe a large amount of interaction on a topic in a limited amount of time (48). Using groups is more economical than interviewing one-on-one. The focus group interview permits assessment of the non-verbal responses in addition to the verbal ones. If the researcher notes a non-verbal response, he or she can probe for clarity and further explanation (45). The main disadvantage of this methodology is that the success of the focus groups depends upon the skill of the moderator (44). If the moderator is not capable of directing the discussion to the research questions, the participants can redirect the interview. A second consideration is that focus groups can foster conformity among participants (49). Responses provided in a group interview are not independent and can be biased if a group member is particularly opinionated or dominant. Proper preparation on the part of the researcher can help minimize or eliminate these detriments.

Focus groups originated in business and were used to obtain a range of opinions on products, with the goal of enhancing marketing strategies (50). One premise related to the use of focus groups is that attitudes and perceptions are not developed in isolation but through interaction with other people (46). A global question is used to stimulate discussion. It is critical for the facilitator to avoid asking leading questions and to avoid controlling the group.

Focus groups have been used in many settings. One common area where this technique is used is as a means of listening to consumers (43). Focus groups are a good way to probe unexpected responses, confirm accurate interpretation of the questions, and understand the context in which opinions are expressed. In focus group research, the researcher can discern why a person holds a belief or attitude. Focus groups are flexible and allow the researcher to tap into a person's emotions in a way a survey cannot (44). Well-executed focus groups have proven to be invaluable in sensing how a particular audience will react to a concept or perceive a situation. This is particularly useful to marketing companies who research how consumers will react to new advertisements and products.

Focus groups have been used in the nutrition field to determine attitudes towards food and health. Trenker and Achterberg (42) used focus groups to evaluate nutrition education materials. After conducting six focus groups, they found that focus groups were a worthwhile evaluation method for nutritionists despite noting a few disadvantages including that the data was not quantitative, responses might have been influenced by group dynamics, and some suggestions made by the group were inappropriate. Trained moderators can minimize these difficulties but when conducting focus groups it is always important to note that the discussion must be structured in order to gain information on the research topic.

Focus groups are an effective way to determine the needs and interests of a target population. McCarthy, Lansing Hartman, and Himes (51) used focus groups to determine the needs and interests of potential participants in worksite cholesterol education programs. They found that focus groups have an advantage over surveys or

questionnaires in that focus groups are nondirective and allow the participants considerable opportunity to comment, explain, and share experiences and attitudes.

Data from focus groups can be analyzed in different ways but it is commonly done using content analysis. The first step of analysis is usually transcription of the data (49). Next the researcher must review the transcripts for accuracy. If using a content analysis approach, the researcher must decide what units of analysis will be counted (52). This may be words, paragraphs, topics, or sections. The researcher reviews the data to find themes and then counts the content fitting into these main themes. This is called category building (52). After the themes have emerged the researcher can build theories. There are many computer programs available to assist with counting and sorting data.

Focus groups are clearly appropriate for research settings which require qualitative information gathering. Understanding which settings are appropriate along with proper training and readiness of the moderator are key issues. Once these issues have been addressed a successful focus group will yield rich, detailed, and insightful information.

# CHAPTER III

# METHODOLOGY

## Purpose of the Study

The purpose of this study was two-fold: 1) to identify the readiness of dietitians to formulate lifelong learning plans as required by *PD 2001* and 2) to identify their attitudes toward *PD 2001* and determine what factors influenced and shaped their beliefs. These two critical issues will impact the future of dietetics and the credentialing process of the health professions in years to come. Successful implementation, through readiness and accepting attitudes are key issues to the future of this profession. The CDR is being closely monitored by other credentialing agencies and a successful implementation will not only improve the stature of dietetics but will also protect the public by assuring that the RD credential is synonymous with safe, well-informed practitioners.

*Professional Development 2001* is based on mandating that dietitians formulate five-year learning plans in order to reach their individual career goals. This in turn will benefit the profession of dietetics as a whole because dietitians will then have directed, targeted, and focused plans for the future. *Professional Development 2001* will only succeed in helping the profession to reach this level of success if each individual dietitian approaches this long-range planning in an effective manner. Currently, there is no information available on the exact nature of the steps or the thought process that dietitians will take when faced with step one of *PD 2001*, Professional Self-Reflection. This step requires that the practitioner reflect on his or her current and future practice in order to formalize both short-term (1-3 years) and long-term (3-5 years) goals. How will dietitians "reflect?" How will they approach the task of goal setting? Will they use any

specific tools or outside assistance? What will be their motivation - a better career, a stronger dietetic profession, or the desire to give improved patient care? Once the thought-processes and methods towards goal setting are understood, effective policy for the profession can be written. Dietetics is the first allied health profession to support a portfolio model of recertification and is providing a precedent for other fields. The success or failure of *PD 2001* will surely impact the profession. This study sought to elucidate the steps and thoughts of dietitians on the most critical part of the recertification plan. Without clearly defined, realistic, and satisfying goals, the remainder of *PD 2001* is simply paperwork to complete. The long-term impact of this study will be to provide educators of dietitians, providers of continuing education, employers, JCAHO and other regulatory bodies, and CDR with information on how dietitians plan for the future. The information gained from this study can be used by these groups to teach needed skills, set policy, and develop educational programs.

The information obtained on attitudes will smooth the transition to the new recredentialing system because once the influential factors have been determined, specific materials and implementation strategies can be developed to address these factors. For example, this study examined whether or not it is helpful to have several different sets of introductory materials for dietitians in different areas of practice. This study also examined the accuracy of the dietitians' understanding of the true requirements of *PD 2001* and determined if there is a need for developing revised materials and scheduling additional general sessions. Overall, this study produced information that will assist with the transition to the new recredentialing system, which may affect the long-term viability of the RD credential.

The specific research questions this study answered were:

1. Do participants currently have formal five-year goals?
2. If yes, how did they formulate those five-year goals?
3. When and how do participants reflect on their current and future practice?
4. Are participants aware of, or do their employers provide, any tools or techniques to assist with goal setting?
5. What are participants' first priorities when considering five-year goals: schedule, pay, the opportunity to be self-directed, the opportunity to apply technical expertise, and/or job duties?
6. What are the attitudes of participants towards *PD 2001*?
7. Did attendance at lectures, delegate reports, or CDR written materials influence the attitude towards *PD 2001*?
8. Are these attitudes based on accurate knowledge about *PD 2001*?
9. Does being an active participant in a state or district dietetic association influence the attitude towards *PD 2001*?
10. Does previous exposure to a similar portfolio method influence the attitude towards *PD 2001*?
11. Do number of years in practice influence the attitude towards *PD 2001*?
12. Does area of practice (clinical, management, or community dietetics) influence the attitude towards *PD 2001*?

Based on the answers to the above questions, a process model describing a recommended series of steps and procedures to assist dietitians in formulating five-year goals was developed by the researcher. These questions served to assess the current

conditions and helped elucidate how dietitians are currently performing goal setting. In order to determine the steps dietitians *should* take when performing the task of goal setting, it was first necessary to see where they are now.

**Preliminary Data**

In order to experience using a focus group methodology and to determine if this was a feasible way to answer the study questions, four preliminary focus groups were conducted on the topic of lifelong learning in relation to *PD 2001*. These preliminary focus groups were held at a state and national dietetic meeting in 1997. The first two focus groups were held at the Florida Dietetic Association Annual Meeting in Marco Island, Florida in July 1997. The second two focus groups were held at the American Dietetic Association Annual Meeting and Exhibition in Boston, Massachusetts in October 1997.

All four sessions were conducted in the same manner. Meeting attendees were informed of the focus groups by a one-page flyer that was distributed at the registration table. The flyer invited any interested dietitian to sign-up in order to attend a focus group to discuss their feelings on *PD 2001* and listed the room location and times. Each focus group was limited to the first ten participants who signed up. During each focus group, participants were seated at a round table in a private room and each session was tape-recorded. Participants were asked to sign a release granting permission for tape-recording.

The preliminary focus groups were asked a series of questions to determine their perception of the future of dietetics, their attitude towards *PD 2001*, and the use of self-assessment tools for goal setting. The tapes were reviewed by the researcher in order to

evaluate the methodology and to compile a summary of the responses. By conducting these sessions, the researcher was able to learn techniques to keep the discussion on track, methods of drawing people into the discussion, and ways of handling emotional participants. After review of the tapes, it was concluded that the participants spoke freely and did not hesitate to give their opinion. There was quality discussion that remained on the topic at all four sessions. These preliminary focus groups gave the researcher experience in moderating focus groups in order to obtain the desired information. When discussion lagged or got off the topic, questions were rephrased and the conversation successfully resumed. Several times the discussion was emotional but refocusing the group served to keep the discussion lively but still useful.

The questions and responses from the pilot focus groups were:

**How has your job changed in the past five years?**

The most frequent response was that the participants had a broader job description including many responsibilities they did not have in the previous five-year period. All participants stated that their workplaces had less staff. One dietitian stated she got much less enjoyment from work now and this comment was met with total agreement from the group. Computer usage was another major area of change. On four occasions participants stated that if they had the opportunity to begin their careers again, they would not choose dietetics. The fields cited as being "better" choices were pharmacy, physical therapy, and occupational therapy. When asked "Where do you see your job going in the next five years?", eight of ten participants in one group predicted that they would be working for a different employer in the coming five years. This same comment was repeated in all other groups. The general comment was that five years was too long to

predict and three years was suggested as more reasonable. The participants repeatedly voiced concern about being committed to a five year learning portfolio with no mechanism for adjusting the plan according to their future needs. The overall belief of the groups was that CDR would "force" them to complete the plan they had submitted and that if their needs changed during the five year credentialing periods because of a new job or new job requirements, there would be no process for incorporating new goals.

**Do you perform annual self-assessments?**

Most of the participants reported doing annual self-assessments as part of their annual performance review for their job. The participants did not view the assessments as a tool for the future but rather a retrospective assessment of what they had accomplished during the past year. The participants were then prompted to discuss whether or not they could envision any assessment that would help them to clarify their future needs. The overall response was that they were often put in situations where they needed to know things immediately and that these situations were unpredictable. For example, one dietitian stated that she had to give a presentation on renal nutrition with one-day notice. The discussion went back to the point that five years was too long. One dietitian commented that she did not know what she would be doing tomorrow so how did "ADA" expect her to write down every single thing she needed to learn for the next five years?

**What type of assistance would help you clarify your educational plans for the next five years?**

This question was met with silence each time it was asked. At this time, the discussion turned to the point that a new plan was not necessary and the participants did not understand why they were being forced to participate in a task (ie. planning a five year

learning portfolio) that they felt was "impossible." Since the purpose of this group was not to discuss the merits of instituting a new credentialing system, the discussion was refocused to the question of what would help them with a plan. The discussion turned back to ADA and promotion of the dietitian. The general belief was that if the profession were "better", the job situation would be more stable. Hence, they could more easily predict what type of knowledge they would need to do their job.

**How do you think the new recertification system will affect the profession?**

The main response to this question was that it would only create more paperwork for the individual and that there would be no major change in the status of the profession as a whole. One participant felt that she might leave the field rather than "go through all of this." The group nodded in support but no one else made that comment. One participant in one group explained to the group that the new system was to make us more accountable to the public in view of licensure. This participant was very upset that mentoring and leadership activities could be part of a learning plan since these did not help the public. The group agreed emphatically and then focused on the new system being too lenient. The general belief was that CDR could not "enforce" all 60,000 plans and therefore, many people would only do the paperwork and nothing else.

These preliminary focus groups helped to refine the future research questions by providing direction and highlighting which issues were key. After reviewing notes and audio-tapes, it was determined that more information on how dietitians will approach reflection and goal setting was needed since the preliminary groups did not have a positive approach for planning. From the preliminary groups, it was clear that reflection has been used as a means of looking back on past accomplishments to protect jobs rather

than as a means to propel careers forward. For *PD 2001* to be successful, more information on this phenomenon is needed in a timely manner in order to allow time for corrective action to be implemented. In addition, attitudes and what shaped those attitudes towards *PD 2001* became a key issue from the four preliminary sessions since the practitioner's attitude influenced his or her answer to all the other questions. Many of the participants in the preliminary focus groups held negative and damaging attitudes towards *PD 2001*. It was deemed important for future research to determine if this would still be the prevailing viewpoint as implementation nears.

**Subject Recruitment**

The state president and/or executive director of forty-four affiliate dietetic associations were sent a letter (Appendix A) outlining this research project. Eight of the 52 total ADA affiliates (fifty states plus Washington DC and Puerto Rico) were not sent a letter because they do not hold an annual meeting or the affiliate had no listed contact name or address on the ADA list. Cooperation and endorsement from CDR was obtained prior to mailing the letters on July 1, 1998. Each affiliate was offered the opportunity to schedule two focus groups as part of their annual meeting agenda. The letter each state received presented this research as a cooperative effort between CDR and Florida International University's (FIU) Department of Dietetics and Nutrition. All states that replied were included in the study: Indiana, Minnesota, Missouri, New Jersey, North Carolina, Oklahoma, South Carolina, and Texas.

The states that participated were instructed to solicit volunteers to participate in the focus groups. Informed consent (Appendix B) and demographic data using a self-

administered questionnaire (Appendix C) were collected from all participants in order to obtain a detailed description and profile of the members of each focus group.

**Instruments**

Data was obtained using the dual methodology of sixteen focus groups plus a self-administered written questionnaire completed by the participants of the focus groups (Appendix C). The researcher developed the questionnaire using the information generated from the preliminary focus groups as a guide. The analysis of the preliminary data highlighted what information would have been helpful had it been collected and provided a framework for the questionnaire. The questionnaire was then refined to be geared toward the specific research questions this study intended to answer.

This dual methodology was utilized to generate demographic data and assist in constructing a profile of each focus group. The questionnaire supported the focus group methodology by providing background data on the participants. In addition, the questionnaire provided additional explanations and clarifications to information gathered in the focus groups. Focus groups were the methodology of choice for this study because of the need to collect in-depth information on personal beliefs, thought processes, and to assess the accuracy of the participants understanding of *PD 2001*. The Focus Group Protocol is included in Appendix D. The researcher learned how to coordinate and moderate focus groups during the preliminary data collection period. The researcher read materials on conducting this type of research and then practiced the techniques at each of the preliminary sessions. By the conclusion of the four preliminary focus groups, the researcher felt comfortable and confident to utilize this methodology. A mailed questionnaire sent to practitioners was considered as an alternate data collection method.

The benefit of the alternative method was that a larger sample of dietitians could be queried. However, the depth of response on a questionnaire was less preferred for fully assessing the in-depth thoughts and attitudes and passionate responses towards *PD 2001*. Also, it would have been difficult to use a questionnaire to determine the accuracy of the respondent's knowledge about *PD 2001* since this would have required that the respondent write down all information known about *PD 2001* in paragraph form. Focus groups provided a method to probe and clarify the respondent's answers. Focus groups provided the forum for a frank, in-depth discussion of the topic with small groups of dietitians in a cost-effective, efficient manner.

The focus groups were scheduled during each state meeting after discussion with the meeting planner. The ideal schedule to reach the widest audience for volunteers was to schedule one group on the first day of the meeting and one group on the second day of the meeting. This was because different people were in attendance on different days. It was also desirable to have one group in the morning and the other in the afternoon in order to attract a variety of participants. Each state complied with these requests. Appendix E, the Focus Group Log, indicates the dates, locations, and number of participants for each focus group. The main requirement for participation was to be credentialed by CDR as an RD. Dietetic technicians were not included in the focus groups. This was assured by verbally asking the group if there were any participants present who did not hold the RD credential. Although the new credentialing process will also affect dietetic technicians, they were excluded from the study in order to maximize the homogeneous nature of the focus group participants.

The sessions were conducted with participants seated at a round table in a quiet, private room. The sessions were audiotaped with the participant's informed consent (Appendix B). Each state was required to post a volunteer/monitor at the door in order to avoid disturbances during the sessions. All states were advised of the requirements and facilities existed in all venues to conduct the sessions in this manner.

Once the participants were seated they were asked to complete the questionnaire. The instrument was previously field tested on two occasions to assure that it was understandable and easy to use. The first field test occurred on February 4, 1999 at the Administrative Council Meeting of the Broward County Dietetic Association. A group of eight dietitians reviewed the questionnaire for content and discussed their interpretation of the meaning of the questions. The questionnaire was modified based on the input. On February 16, 1999, the revised questionnaire was field tested at the general membership meeting of the Broward County Dietetic Association. Thirty-two completed questionnaires were returned to the researcher. These were reviewed and again, the questionnaire was modified to make the questions clearer and the questionnaire easy to complete.

Following completion of the self-administered written questionnaire, the focus groups were asked the following probing questions to stimulate discussion:

1. What do you understand is the purpose of *PD 2001*?
2. What do you understand are the requirements of *PD 2001*?
3. Step one is Professional Self-Reflection. How do you "reflect" on your career and set your goals?
4. How do you think dietitians SHOULD go about setting five-year goals?

5. How do you think *PD 2001* will affect the dietetics profession?

6. How do you think *PD 2001* will affect you as an individual practitioner?

These questions were formulated by using the preliminary focus groups as a guide. The analysis of the preliminary focus groups assisted in construction of the focus group questions by highlighting which questions provided insightful responses and which fell flat and needed refinement.

The flow of discussion led to additional questions from both the focus group leader and the participants. Comments and threads of discussion were sparked by the probing questions. The discussion was allowed to free-flow as long as it remained on the topic with pertinent comments. If discussion strayed, the focus group leader redirected the group back to the topic. The focus group questions provided information, which when combined with the data from the questionnaire, answered the study questions.

**Data Triangulation**

Table 1 summarizes the questions that this study intended to answer and the research methodology that was employed in answering each question. This table has a column for each methodology – the questionnaire and the focus groups. Next to each study question, the response of "yes" or "no" indicates whether or not that particular question was answered by the corresponding methodology. For example, the questionnaire was utilized to gather background information, yes or no answers, and short answers. The focus groups were used to clarify and expand the reasons for the answers on the questionnaire. Thus, some study questions were answered by both methodologies while other study questions were answered by only one methodology.

The research design is enhanced by this dual methodological approach. The data consistency or reliability is improved due to the repeated measures of using a written questionnaire in addition to focus groups to clarify and verify the responses. From a research design standpoint, once a proposition has been confirmed by at least two independent measurement processes, the uncertainty of its interpretation is greatly reduced. The triangulation of the measurement process is far more powerful evidence supporting the proposition than any single data collection approach (54).

**Data Analysis**

After the focus groups were conducted, the audiotapes were transcribed verbatim. In total, the focus groups generated 643 pages of text. The text was analyzed using the Nonnumerical Unstructured Data - Indexing, Searching, & Theorizing (NUD*IST 4) computer program made by Qualitative Solutions and Research Ltd. and distributed by Scolari/Sage Publications Software. NUD*IST 4 is designed to assist in analyzing qualitative data in an organized manner similar to content analysis. Content analysis is analysis by topic. When conducting this type of analysis, the researcher reads the entire transcript and identifies several important topics (53). These topics then become the primary categories to sort data. Searching for key words related to the categories is the next step. The NUD*IST program performs text and pattern searches in order to identify trends and allow the researcher to build theories. Specific key words were searched for and patterns emerged from the data. During the computer analysis, the data was reviewed manually to adjust for possible errors such as one person expressing the same opinion repeatedly or speaking for others. The researcher then drew conclusions from the data.

Table 1. Dual methodological plan to answer study questions

| Study question | Data collected by questionnaire | Data collected by focus group |
|---|---|---|
| Do participants currently have formal five-year goals? | Yes | Yes |
| If yes, how did they formulate those five-year goals? | No | Yes |
| When and how do participants reflect on their current and future practice? | No | Yes |
| Are participants aware of, or do their employers provide, any tools or techniques to assist with goal setting? | No | Yes |
| What are participants' first priorities when considering five-year goals: schedule, pay, the opportunity to be self-directed, the opportunity to apply technical expertise, and/or job duties? | Yes | Yes |
| What are the attitudes of participants towards *PD 2001*? | No | Yes |
| Are these attitudes based on accurate knowledge about *PD 2001*? | No | Yes |
| Does previous exposure to a similar portfolio method influence the attitude towards *PD 2001*? | No | Yes |
| Did attendance at lectures, delegate reports, or CDR written materials influence the attitude towards *PD 2001*? | Yes | Yes |
| Do number of years in practice influence the attitude towards *PD 2001*? | Yes | Yes |

Table 1. Dual methodological plan to answer study questions (Continued)

| Study question | Data collected by questionnaire | Data collected by focus group |
|---|---|---|
| Does area of practice (clinical, management, or community dietetics) influence the attitude towards *PD 2001*? | Yes | Yes |
| Does being an active participant in a state or district dietetic association influence the attitude towards *PD 2001*? | Yes | Yes |

Prior to the collection of data, the researcher designed a process model for determining five-year goals. This model (Figure 1, Page 47) represents the sequence of events in determining five-year goals as defined by the researcher. It was important to have a beginning point from which to design the study and determine the focus group questions. This preliminary model served that purpose and was based on the data collected during the four pilot focus groups. By having a preliminary model, the researcher was able to have a starting point for analysis.

In this model, the current level of practice is the point at which the practitioner enters the current five-year credentialing period. The external factors include things happening in the world that will affect the practitioner during the next credentialing period. Factors include new regulations in healthcare, legislative changes such as reimbursement for services, or new medical or technological developments. Examples of internal factors are the desire for specific job duties, the opportunity to make clinical decisions, or the desire to be self-directed. Possible strategic issues influencing goal setting are economics, family responsibilities, and geographic restrictions. Once all of these internal, external,

and strategic issues are taken into account, it is expected the dietitian forms a learning plan or an action plan that will lead to recertification.

The focus group analysis determined how dietitians formulate their action plan or goals. The focus group analysis was used to determine how each group compares to this model and assisted in refining the model. The questionnaires provided a description of the particular characteristics of each group. The sixteen focus groups were kept separate during the analysis in order to determine how dietitians that have had particular experiences (involvement in state or district associations, exposure to similar models, attendance at delegates reports, etc.) responded to *PD 2001*. This information provided a description of what characteristics of dietitians may have influenced attitudes and shaped methods for constructing five-year goals and thereby, answered the specific questions of the study. Once all the group data was analyzed, a final process model (Figure 2, page 108) based on the input from all of the focus groups was developed. The answers to the study questions provided insight into the process that is now used by the dietitians and provided the framework for the model.

A one-way analysis of variance (ANOVA) was calculated for the number of years in dietetic practice to determine if there was a difference between the groups with regards to level of dietetic practice. It was determined that the other demographic data categories were not suitable for parametric statistics due to the small size of the groups and the types of responses. The remainder of the data either required a positive or negative response or a five-point Likert scale rating. These types of responses were best suited for analysis with NUD*IST 4 rather than parametric statistics.

A limitation of the results of this study is that the information generated cannot be generalized to all other states or all other dietitians. It is intended to give an in-depth picture of the approaches, attitudes, and the factors that shaped these participants attitudes

at a particular point in time. These responses may change with time or could change with input from colleagues or future CDR publications.

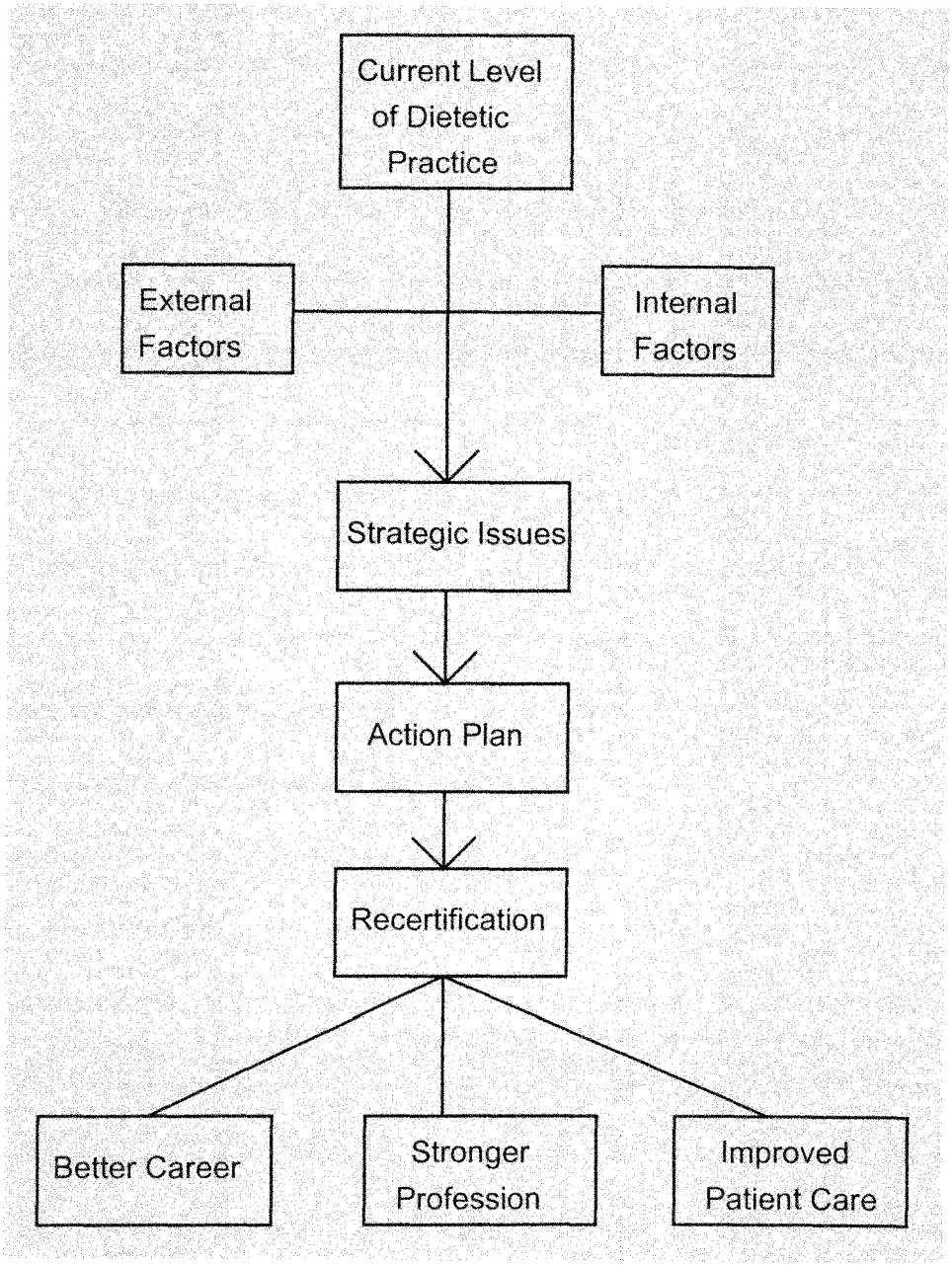


Figure 1. Process Model for Determining Professional Five Year Goals

# CHAPTER IV

# RESULTS AND DISCUSSION

## Background of the Participants

A total of 132 subjects participated in sixteen focus groups. Each subject contributed data via the dual methodology of completion of a questionnaire and participation in a focus group. The minimum number of participants in any focus group was seven and the maximum number was ten. Prior to the start of each focus group, the participants completed the informed consent form and questionnaire yielding 132 properly fully-completed questionnaires. The questionnaires provided demographic data used to compile information on key characteristics of the participants and served as a means to triangulate certain data gathered in the focus groups. Taken together, the focus groups and the questionnaires provided an in-depth picture of the participants' thought patterns towards professional development issues.

## Number of Years as A Credentialed Practitioner

The questionnaire asked each participant to report the number of years he or she has been credentialed as a Registered Dietitian. Table 2 outlines the number of years each participant has held the RD credential. The average participant's length of time as a credentialed practitioner was 13.4 ± 7.8 years. The median was 14.0 years.

The focus group participants had a wide range of experience: from six months to 48 years. There were newly credentialed dietitians with approximately six months of experience as well as those who reported to be anticipating retirement. The range was six months to 48 years of experience. Each of the sixteen groups had a mix of participants, which was reflected by the large standard deviations. One-way ANOVA

Table 2. Length of time as a credentialed dietitian as reported on the questionnaire

| State and group number | n | Number of Years as RD | | |
|---|---|---|---|---|
| | | Mean ± SD | Median | Range |
| Oklahoma 1 | 9 | 9.5 ± 5.9 | 8.0 | 4 - 22 |
| Oklahoma 2 | 7 | 9.1 ± 6.7 | 8.5 | 1 - 21 |
| Texas 1 | 10 | 13.1 ± 8.3 | 12.0 | 3.5 – 30 |
| Texas 2 | 9 | 15.8 ± 7.1 | 18.0 | 1.5 – 22 |
| Indiana 1 | 7 | 15.4 ± 7.2 | 15.0 | 5 - 26 |
| Indiana 2 | 7 | 12.9 ± 8.0 | 13.0 | 2 – 24 |
| Missouri 1 | 10 | 11.2 ± 9.3 | 8.0 | 0.5 – 27 |
| Missouri 2 | 8 | 15.8 ± 8.0 | 15.5 | 6.5 - 26 |
| Minnesota 1 | 8 | 14.9 ± 5.5 | 14.0 | 8 – 22 |
| Minnesota 2 | 8 | 17.1 ± 8.1 | 18.0 | 4 - 29 |
| S. Carolina 1 | 8 | 12.9 ± 10.3 | 11.5 | 1 - 30 |
| S. Carolina 2 | 9 | 19.6 ± 9.9 | 19.0 | 6 - 30 |
| New Jersey 1 | 10 | 15.8 ± 6.5 | 16.5 | 2.5 - 24 |
| New Jersey 2 | 8 | 13.4 ± 10.7 | 16.0 | 1 - 28 |
| N. Carolina 1 | 7 | 12.8 ± 6.3 | 13.0 | 5 - 22 |
| N. Carolina 2 | 7 | 15.3 ± 14.8 | 13.0 | 5 - 48 |
| Total | 132 | 13.4 ± 7.8 | 14.0 | 0.5 – 48 |

indicated an F ratio of .8568 between groups meaning that no two groups were significantly different ($p = 0.05$) with respect to number of years in practice.

**Career History**

The questionnaire methodology was utilized to ask each participant if dietetics was their first career or if they had worked in a different profession prior to entering dietetics. Table 3 shows the career history of the participants. Seventy-seven percent or 101 participants reported that dietetics was their first and only career. The other 31 participants, who represented 23 percent of the group, had a previous career in another field. All of the participants (100%) in three focus groups, representing the states of Missouri, Minnesota, and New Jersey, responded that dietetics was their first and only career. The questionnaire did not ask them to name the previous career but during the second methodology, the focus group discussion, several participants volunteered this information. The careers that were mentioned, according to the transcripts, were communications, lab technology, business, sales, and teaching.

Each participant was asked to indicate his or her major professional work area on the questionnaire. Four choices were given with instructions to select clinical, management, community nutrition, or education of dietetic practitioners. If participants were not working, they wrote in unemployed. The largest number of participants reported working in the clinical area (Table 4). Fifty-nine people described their main job as clinical nutrition. This represented 45 percent of the participants. Management and community nutrition had almost the same number of participants. Twenty-six people reported their main duties in the management area while 29 worked in community nutrition.

Table 3. Career history as reported on the questionnaire

| State and group number | n | % Responses | |
|---|---|---|---|
| | | Dietetics has been my only career | I switched to dietetics after working in another profession |
| Oklahoma 1 | 9 | 67 | 33 |
| Oklahoma 2 | 7 | 86 | 14 |
| Texas 1 | 10 | 70 | 30 |
| Texas 2 | 9 | 55 | 45 |
| Indiana1 | 7 | 86 | 14 |
| Indiana2 | 7 | 86 | 14 |
| Missouri 1 | 10 | 80 | 20 |
| Missouri 2 | 8 | 100 | 0 |
| Minnesota 1 | 8 | 75 | 25 |
| Minnesota 2 | 8 | 100 | 0 |
| S. Carolina 1 | 8 | 87 | 13 |
| S. Carolina 2 | 9 | 45 | 55 |
| New Jersey 1 | 10 | 100 | 0 |
| New Jersey 2 | 8 | 62 | 38 |
| N. Carolina 1 | 7 | 57 | 43 |
| N. Carolina 2 | 7 | 71 | 29 |
| Total | 132 | 77 | 23 |

Table 4. Major professional work area as reported on the questionnaire

| State and group number | % Responses | | | | |
|---|---|---|---|---|---|
| | Clinical | Manage-ment | Community | Education of dietetic practitioners | Unemployed |
| Oklahoma 1 | 44 | 0 | 56 | 0 | 0 |
| Oklahoma 2 | 43 | 14 | 29 | 0 | 14 |
| Texas 1 | 40 | 20 | 10 | 0 | 30 |
| Texas 2 | 44 | 33 | 23 | 0 | 0 |
| Indiana 1 | 43 | 0 | 43 | 0 | 14 |
| Indiana 2 | 42 | 0 | 29 | 29 | 0 |
| Missouri 1 | 30 | 30 | 40 | 0 | 0 |
| Missouri 2 | 50 | 12.5 | 12.5 | 25 | 0 |
| Minnesota 1 | 50 | 12.5 | 25 | 12.5 | 0 |
| Minnesota 2 | 13 | 87 | 0 | 0 | 0 |
| S. Carolina 1 | 50 | 25 | 0 | 12.5 | 12.5 |
| S. Carolina 2 | 33 | 12 | 33 | 22 | 0 |
| New Jersey 1 | 70 | 10 | 10 | 0 | 10 |
| New Jersey 2 | 50 | 25 | 12.5 | 0 | 12.5 |
| N. Carolina 1 | 44 | 14 | 14 | 14 | 14 |
| N. Carolina 2 | 72 | 14 | 14 | 0 | 0 |
| Total | 45 | 20 | 22 | 6.5 | 6.5 |

This equates to 20 and 22 percent, respectively. There were nine educators present and nine unemployed participants.

Every group had at least one member from the clinical area. The first group in Oklahoma and both groups in Indiana did not have any members from the management sector. All groups had a member working in the community area except for two: the second group held in Minnesota and the first group held in South Carolina. Six groups had members who were dietetics educators. These groups were in Indiana, Missouri, Minnesota, both groups in South Carolina, and one group in North Carolina.

The focus group demographics on work area corroborate what was found in the 1997 membership database of the ADA (55). According to ADA, clinical nutrition and food and nutrition management accounts for almost two-thirds of all primary positions held by RDs. Sixty-five percent of the focus groups participants worked in these areas.

**Level of Involvement in State and/or District Dietetic Associations**

On the questionnaire, participants were asked to rate their level of involvement in their state and/or district dietetic association. Involvement was rated on a five-point Likert scale with the number one indicating uninvolved and the number five representing the highest level of involvement. Table 5 shows the level of involvement the participants had in their state and/or district dietetic associations. Seventy, 53 percent, rated their level of involvement in categories 4 or 5 meaning that they felt they were very involved. Thirty-seven, 28 percent, rated their involvement in categories 1 or 2 indicating that they were not involved. In the middle category, level 3, there were 25 subjects representing 19 percent of the total number of participants. The highest levels of

Table 5. Level of involvement in district and/or state dietetic association(s)

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Involved..... | | | | .....Involved |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 12 | 22 | 22 | 22 | 22 |
| Oklahoma 2 | 7 | 29 | 0 | 29 | 13 | 29 |
| Texas 1 | 10 | 20 | 30 | 0 | 0 | 50 |
| Texas 2 | 9 | 11 | 22 | 34 | 11 | 22 |
| Indiana 1 | 7 | 0 | 0 | 0 | 14 | 86 |
| Indiana 2 | 7 | 0 | 14 | 29 | 0 | 57 |
| Missouri 1 | 10 | 20 | 30 | 20 | 20 | 10 |
| Missouri 2 | 8 | 0 | 25 | 25 | 0 | 50 |
| Minnesota 1 | 8 | 0 | 0 | 25 | 13 | 62 |
| Minnesota 2 | 8 | 0 | 0 | 25 | 13 | 62 |
| S. Carolina 1 | 8 | 0 | 0 | 25 | 37.5 | 37.5 |
| S. Carolina 2 | 9 | 11 | 33.5 | 11 | 33.5 | 11 |
| New Jersey 1 | 10 | 0 | 70 | 10 | 20 | 0 |
| New Jersey 2 | 8 | 62 | 0 | 13 | 0 | 25 |
| N. Carolina 1 | 7 | 0 | 0 | 0 | 29 | 71 |
| N. Carolina 2 | 7 | 0 | 0 | 43 | 0 | 57 |
| Total | 132 | 11 | 17 | 19 | 14 | 39 |

involvement were found in Indiana, Minnesota, and North Carolina. This was due to the fact that the affiliate associations in these states recruited participants from their administrative councils. The other states solicited volunteers from the general membership thereby giving a wider spread in the level of involvement.

The level of involvement in district and/or state dietetic associations was also analyzed by major professional work area (Table 6). No single professional work area stood out as being more involved than the other areas. For example when looking at the very involved people who classified themselves as either a level 4 or level 5 on the Likert scale, 33 of the 59 clinicians (55.9%) described themselves as very involved while 13 of the 26 managers (50%) were also very involved. Of the nine educators, five (55.5%) classified themselves as very involved. In the community area, 16 out of 29 (55.2%) were very involved. The lowest level of involvement was seen in the unemployed category with only 3 of the 9 (33.3%) unemployed participants rating themselves as very involved. Of the employed participants, no one group was considerably more involved than another.

**Performs Annual Self-Assessments**

The questionnaire asked each participant if they performed annual self-assessments. Table 7 shows that 54 participants (41%) presently perform annual assessments while 78 (59%) do not. Each group had participants in both categories and no pattern emerged from the data.

Table 6. Percentage of participants from each major professional work area classified by level of involvement in district and/or state dietetic associations

| | % Responses | | | | |
|---|---|---|---|---|---|
| | Major Professional Work Area | | | | |
| | Clinical | Manage-ment | Com-munity | Education of dietetic practitioners | Unem-ployed |
| | n= 59 | n= 26 | n= 29 | n= 9 | n= 9 |
| Involvement Level 1 (Not involved) | 11.9 | 7.7 | 13.8 | 0 | 11.2 |
| Involvement Level 2 | 16.9 | 11.5 | 17.2 | 22.2 | 33.3 |
| Involvement Level 3 | 15.3 | 30.8 | 13.8 | 22.2 | 22.2 |
| Involvement Level 4 | 11.9 | 11.5 | 27.6 | 11.2 | 0 |
| Involvement Level 5 (Actively involved) | 44.0 | 38.5 | 27.6 | 44.4 | 33.3 |
| Total | 100 | 100 | 100 | 100 | 100 |

Table 7. Performs annual professional self-assessments as reported on the questionnaire

| State and group number | n | % Responses | |
|---|---|---|---|
| | | Yes | No |
| Oklahoma 1 | 9 | 67 | 33 |
| Oklahoma 2 | 7 | 29 | 71 |
| Texas 1 | 10 | 40 | 60 |
| Texas 2 | 9 | 33 | 67 |
| Indiana 1 | 7 | 29 | 71 |
| Indiana 2 | 7 | 57 | 43 |
| Missouri 1 | 10 | 20 | 80 |
| Missouri 2 | 8 | 38 | 62 |
| Minnesota 1 | 8 | 50 | 50 |
| Minnesota 2 | 8 | 50 | 50 |
| S. Carolina 1 | 8 | 25 | 75 |
| S. Carolina 2 | 9 | 22 | 78 |
| New Jersey 1 | 10 | 50 | 50 |
| New Jersey 2 | 8 | 50 | 50 |
| N. Carolina 1 | 7 | 57 | 43 |
| N. Carolina 2 | 7 | 43 | 57 |
| Total | 132 | 41 | 59 |

Table 8. Percentage of participants who perform annual self-assessments classified by major professional work area

| | % Responses | | | | |
|---|---|---|---|---|---|
| | Major Professional Work Area | | | | |
| | Clinical | Manage-ment | Com-munity | Education of dietetic practitioners | Unem-ployed |
| | n=59 | n=26 | n=29 | n=9 | n=9 |
| Performs annual self-assessments | 38.9 | 53.8 | 44.8 | 44.4 | 0 |
| Does not perform annual self-assessments | 61.1 | 46.2 | 55.2 | 55.6 | 100 |
| Total | 100 | 100 | 100 | 100 | 100 |

The questionnaire data was then used to determine if the people who performed annual assessments were from a particular practice area (Table 8). The highest percentage of self-assessments (53.8%) were performed by those in the management area. Those in community and education of practitioners performed self-assessments at approximately the same rate, 44 percent. Of the clinicians, who constituted the largest group, only 38.9 percent indicated that they performed annual self-assessments.

A possible explanation for the highest percentage in the management area is that managers are usually responsible for conducting performance appraisals of their

employees and many performance appraisals require a self-assessment. This may predispose them towards this activity.

The questionnaire provided the preliminary information as to the participants' background in dietetics and allowed the researcher to gain an understanding of types of participants. In sum, it was established from the questionnaire that all groups contained participants at early, middle, and late career stages; that most groups had at least one member who had worked in a career besides dietetics; that all work areas of the profession were represented including unemployed dietitians; that the level of involvement in dietetic associations varied and was influenced by the manner in which participants were selected; and that no single work area was more involved in dietetic associations than another. In addition, the majority of the participants did not conduct annual self-assessments. Furthermore, analysis of the focus group demographics indicated that no single group was different in composition than another. The same researcher led all sixteen focus groups and served as a consistent observer. Observation confirmed that no group behaved very differently or stood out as being different than the others.

**Focus Group Data**

Focus groups provided the opportunity to obtain in-depth responses to complement the questionnaire responses and put the remainder of the questionnaire in context. To analyze the focus group data, the audio-recordings of the focus groups were transcribed and reviewed using NUD*IST version 4 as a tool for searching the document based on the study questions. The documents were imported into the program as sixteen separate documents totaling 643 pages of text. Each document was given a number from one to

sixteen and named based on the state of origin and the group number within that state. The documents were reviewed for accuracy compared to the audio-tapes and broken into text units by placing a "hard return" where the text unit was to end. For this analysis, the text was broken into a new unit every time the speaker changed. The text was then reviewed by hand for content and to find main categories for the data. NUD*IST was directed to search for patterns of text or strings of characters based on the key words of the categories in order to answer the study questions. The program gave unit counts for every search and allowed the researcher to view the origin of the matching text to determine the context in which it was originally spoken. Final tabulated counts reflect the removal of the focus group leader comments and addition of responses to questions that may or may not contain key words. For example, the focus group leader asked the question "do you have five-year goals?" A response that stated "I think *that* is too long a period of time" was added to the final count even though it did not contain the exact search phrase. Multiple searches and careful review of the transcripts in context, allowed the researcher to find recurring themes and draw conclusions in order to answer the study questions. Questionnaire data was used to confirm and/or expand the conclusions. For each of the following study questions, it is indicated which of the two methodologies were employed in analysis and the patterns of responses identified.

**Study Question 1: Do participants currently have formal five-year goals?**

This question was asked both on the questionnaire and in the focus group. Table 9 lists the geographic location of each of the sixteen focus groups and the response given by the participants on their questionnaires. Most groups had at least some participants that did have five-year goals except for Indiana, which did not have any participants with

Table 9. Has formal professional five-year goals as reported on the questionnaire

| State and group number | n | % Responses Yes | No |
|---|---|---|---|
| Oklahoma 1 | 9 | 56 | 44 |
| Oklahoma 2 | 7 | 29 | 71 |
| Texas 1 | 10 | 20 | 80 |
| Texas 2 | 9 | 22 | 78 |
| Indiana 1 | 7 | 0 | 100 |
| Indiana 2 | 7 | 0 | 100 |
| Missouri 1 | 10 | 10 | 90 |
| Missouri 2 | 8 | 25 | 75 |
| Minnesota 1 | 8 | 37.5 | 62.5 |
| Minnesota 2 | 8 | 37.5 | 62.5 |
| S. Carolina 1 | 8 | 37.5 | 62.5 |
| S. Carolina 2 | 9 | 33 | 67 |
| New Jersey 1 | 10 | 20 | 80 |
| New Jersey 2 | 8 | 25 | 75 |
| N. Carolina 1 | 7 | 29 | 71 |
| N. Carolina 2 | 7 | 29 | 71 |
| Total | 132 | 26 | 74 |

five-year goals. Indiana also had no participants working in the management area of practice. There may be a relationship between these two characteristics. The other individual groups were mixed with some participants having goals and some not having them. Overall, 34 or 26 percent of the 132 participants had five-year goals. The majority, 98 (78%), did not have formal professional five-year goals.

Table 10 shows the breakdown of which participants had formal five-year goals classified by major professional work area. Of the 59 clinicians, 15 (25.5%) had formal goals. In the management area, eight (30.8%) of the 26 managers had formal goals. In the community area, 7 (24.1%) of the 29 participants had formal goals. One third of the nine educators had five-year goals while only one of the nine unemployed participants had set professional goals. During the focus groups, the managers spoke most frequently about being required to set goals for their jobs. This observation was reflected in the data as the management area had the highest percentage of participants (30.8%) with five-year goals.

The survey data was clarified by the second methodology, the focus group discussion. The same question about having five-year goals was asked in the focus group in order to gain an explanation as to the reason why they did or did not have goals. Although the questionnaire was able to provide raw numbers, the reason for the low overall percentage (26%) of participants having professional goals was revealed in the discussion. The transcripts were searched for key words and phrases including goal setting, five-year goals, goal setting skills, and writing goals. After responding yes or no to the question of five-year goals, participants then had two types of explanatory responses. These responses were revealed after reading the transcripts several times and noting the

Table 10. Percentage of participants having formal professional five-year goals classified by major professional work area

| | % Responses | | | | |
|---|---|---|---|---|---|
| | Major Professional Work Area | | | | |
| | Clinical | Manage-ment | Com-munity | Education of dietetic practitioners | Unem-ployed |
| | n= 59 | n= 26 | n= 29 | n= 9 | n= 9 |
| Has five-year goals | 25.5 | 30.8 | 24.1 | 33.3 | 11.2 |
| Does not have five-year goals | 74.5 | 69.2 | 75.9 | 66.7 | 88.8 |
| Total | 100 | 100 | 100 | 100 | 100 |

recurring themes. Researcher observation and recall also helped identify the initial categories of responses.

The first group of patterned responses focused on the skill needed to actually write goals while the second set of responses dealt with the length of time in question which is a five-year period. Table 11 indicates the number of text units, by group, related to thelack of skills needed to write goals and the five-year time frame. There were a total of 20 comments directly related to the skills needed to write goals, while 27 comments were made about the length of time being too long to conceptualize.

Table 11. Key word search results for "Do you have professional five-year goals?"

| State and group number | Units* related to lack of skills n | Units* related to five-year period n |
|---|---|---|
| Oklahoma 1 | 0 | 1 |
| Oklahoma 2 | 0 | 3 |
| Texas 1 | 1 | 2 |
| Texas 2 | 1 | 1 |
| Indiana 1 | 1 | 1 |
| Indiana 2 | 3 | 3 |
| Missouri 1 | 0 | 2 |
| Missouri 2 | 4 | 2 |
| Minnesota 1 | 2 | 0 |
| Minnesota 2 | 1 | 1 |
| S. Carolina 1 | 0 | 1 |
| S. Carolina 2 | 0 | 1 |
| New Jersey 1 | 3 | 3 |
| New Jersey 2 | 2 | 0 |
| N. Carolina 1 | 1 | 2 |
| N. Carolina 2 | 1 | 4 |
| Total | 20 | 27 |

*Unit = One statement or comment by a single speaker.

Practitioners stated they did not feel they had the necessary skill or knowledge on how to actually write goals. There were several members of groups who believed that this is a skill that should be taught in school. Many were concerned about the proper way to structure goals and what wording to use. The initial responses dealt with the process of writing goals and not on the activity of conceptually forming goals. On three occurrences, the focus groups contained participants who were educators of dietetic practitioners and they voiced that their educational programs were indeed making this a required part of a senior course. For example, one educator from Minnesota stated, "We are starting portfolios and quarterly evaluations where the student puts down what they are going to do to pursue goals." On two occurrences, educators who were present agreed that this should be taught but that it was not part of their current curriculum.

The groups were pressed into further discussion to elucidate what they themselves were going to do about acquiring these needed skills. Researcher observation showed that when the participants were asked how they would go about obtaining the required skills for goal setting, they did not respond with a plan for themselves. The solutions that were offered involved putting the responsibility on someone else – namely the dietetic associations. There were several suggestions that the national, state, and district dietetic associations should assist in helping their members develop these skills. The most common suggestion was that hands-on seminars should be scheduled. It was recommended that seminars should be held shortly before the *PD 2001* forms were due and anyone who was working on those forms could attend the seminar and would be coached through the process. The necessary skills would be taught throughout the day. The outcome of the daylong seminar would be the completion of the necessary forms.

The groups that suggested this felt that it would be beneficial and more pleasant to complete this task with their colleagues in the presence of a leader that would assure that they completed the task.

The second set of responses focused on the fact that most people felt that five years was too long a time period in a profession that is undergoing rapid changes due to the larger changes in the overall United States healthcare system. The most typical response was "a lot can happen in five years." This theme emerged from all groups except the first group in Minnesota and the second group in New Jersey.

Several suggestions were made that perhaps three years was a better choice. This was met with the concern that CDR would not have sufficient personnel to review the portfolio process for all credentialed members this frequently and if they were to accomplish this, the cost to the practitioner would surely increase. The focus group participants were concerned with costs and did not want costs to rise. Focus groups provided a superb forum for observation and the researcher observed strong, hostile voices and definite opinions on the matter of costs. These participants were adamant that they would not tolerate more fees to maintain their credential.

The focus group leader made the suggestion that although CDR only required submission of this process every five years, it would be advisable to review their goals on a more frequent basis. Those who were required to submit annual performance reviews were in agreement and said they would probably do this. Two groups suggested that CDR require annual updates to be submitted. Again, this was discouraged by other members of the focus groups as not being a cost-effective option. The focus groups were

redirected to accept a five-year credentialing period in order to move on to further discussion.

**Study Question 2: If yes, how did they formulate those five-year goals?**

During the focus groups, the 34 participants who had previously formulated five-year goals were asked about the process that they used to accomplish this task. Their comments brought additional comments from the participants without goals and led to a discussion on how dietitians formulate goals.

Analysis of the transcripts showed a pattern of responses concerning two individual situational variables. The first situation that influenced their goals was the type of job that was available to them and the second was child-care. Table 12 shows the number of comments by group relating to these two themes. The transcripts were searched for key words that included job availability, setting goals, find a job, child, children, childcare, babysitter, time, new job, and healthcare changing.

The first trend to emerge from the data for this question was the lack of certain types of jobs available for dietitians. For example, a New Jersey participant summed up the job situation by stating, " I basically look at what is going on in the workforce. I have been with an HMO that went through a merger and now work for a hospital system. I look at where the organization is going and where the trends are, and that is how I decide on what I am going to do to be marketable as an employee to that institution or outside of that institution." This theme was repeated as the most pressing issue in deciding goals. Many people expressed the fact that they had witnessed a decrease in clinical nutrition jobs and were eager to attain skills that would make them valuable to their employer or

Table 12. Key word search results for "How did you set your five-year goals?"

| State and group number | Units* related to job availability<br>n | Units* related to family/child concerns<br>n |
|---|---|---|
| Oklahoma 1 | 2 | 1 |
| Oklahoma 2 | 3 | 3 |
| Texas 1 | 6 | 5 |
| Texas 2 | 3 | 2 |
| Indiana 1 | 5 | 6 |
| Indiana 2 | 3 | 3 |
| Missouri 1 | 2 | 2 |
| Missouri 2 | 5 | 3 |
| Minnesota 1 | 3 | 1 |
| Minnesota 2 | 4 | 2 |
| S. Carolina 1 | 4 | 5 |
| S. Carolina 2 | 2 | 6 |
| New Jersey 1 | 4 | 4 |
| New Jersey 2 | 4 | 5 |
| N. Carolina 1 | 3 | 2 |
| N. Carolina 2 | 1 | 5 |
| Total | 54 | 55 |

* Unit = One statement or comment by a single speaker.

able to obtain employment elsewhere. One dietitian voiced that she loved pediatric nutrition but in her geographic area there was very little chance of getting a job in pediatrics. She continued to say that it would be useless to have a goal of gaining expertise in pediatrics when her paying job forced her in a different direction. Every focus group confirmed that healthcare was different now and that there was a need to defend their positions in order to keep those positions. This need was clearly the main force driving goal formation.

A second situational problem that concerned many participants was the need to provide their own children with proper childcare. This limited the time many participants were able to spend traveling to seminars and courses and eliminated the option of returning to school for a graduate degree. Most of the graduate courses are held in the evening and this interfered with their home schedules. Many participants voiced that they would certainly like to take advantage of more of the educational opportunities including professional meetings but that their home-life and the cost of such activities made it prohibitive.

Beyond the situational variables, the main influence on goals was the needs of the employer. Most focus group participants voiced the fact that they were doing jobs they had never imagined such as managing several departments. One participant from Indiana stated that when she went to school she always thought she would be a clinical dietitian but as those jobs disappeared, she was offered a position managing the foodservice department. She continued to say that she then had an emergent need for information on purchasing, budgeting, and foodservice equipment. Many dietitians who now find themselves in situations they could have never predicted repeated this theme. Several

people who held management jobs stated that they needed to set goals for their department and that those departmental goals then became their goals. For example, a participant from Indiana stated that if the department goal was to maintain a certain dollar amount for food per patient, the manager then needed to learn techniques for cost-containment and this would become her goal.

A theme emerged that the process of setting five-year goals would not allow sufficient flexibility for these types of situations. The focus group leader pointed out that any credentialed dietitian could submit an updated plan to CDR if their goals had substantially changed. This comment was met with either surprise or resentment. Many people mistakenly believed that the goals were binding. Others were upset that they were required to check-in with CDR as if they were children.

There were no formal, systematical ways to setting goals discussed by the participants. Four participants had read books by Stephen Covey and were familiar with his methods but there was no trend to this. Two people used the word "type A" personality to describe themselves and said they need everything on paper.

**Study Question 3: When and how do participants reflect on their current and future practice?**

The focus group moderator introduced the participants to the term "reflection" as the first step required by *PD 2001*. Reflection was explained to the participants as an activity whereby they would look at their current job tasks, their current job skills, and what they liked and disliked in their professional lives in order to begin planning a future direction. Although this terminology was new to the participants, most were in agreement that they had indeed "reflected" on their careers at one point or another. The participants believed

that *PD 2001* was going to require them to reflect in a formal, prescribed manner. Table 13 shows the transcript analysis by group for this question of reflection. Key words used for searching included reflect, reflection, changing jobs, future direction, annual review, performance appraisal, and unhappy. Two trends emerged from the analysis. The first group of patterned responses was related to performing reflection as an informal activity to be done at any time. There were 42 text units relating to reflection as an unstructured task. The second pattern was that reflection was part of a job requirement and was connected to the annual performance appraisal. Thirty-seven text units pertained to reflection as a job requirement.

During every focus group, there was a comment that although the participants may reflect now, it was usually an informal process and did not have any structure or organized time interval. For example, several responses involved laughing or smirking at the question and comments that included "in my car", "in the shower", and "when I am fed-up with my job." Further probing of these responses revealed that these participants had no formal system for reflection. These people usually thought about their careers while doing something else or when they were unhappy and seeking an outlet for their discontent with their current situation. The participants expressed discontent with their jobs frequently and this was a usual impetus for their reflection.

The second response pattern that emerged from this query was that participants who held positions in large healthcare organizations were required to complete annual performance evaluations as part of their job. Participants reported that the performance reviews focused mainly on the current job and was usually a retrospective process. The

Table 13. Key word search results for "How and when do you reflect on your current and future practice?"

| State and group number | Units* related to reflection as an informal activity n | Units* related to reflection as part of a job requirement n |
|---|---|---|
| Oklahoma 1 | 2 | 2 |
| Oklahoma 2 | 1 | 1 |
| Texas 1 | 2 | 4 |
| Texas 2 | 2 | 3 |
| Indiana 1 | 2 | 0 |
| Indiana 2 | 3 | 3 |
| Missouri 1 | 4 | 0 |
| Missouri 2 | 3 | 2 |
| Minnesota 1 | 4 | 4 |
| Minnesota 2 | 4 | 2 |
| S. Carolina 1 | 3 | 3 |
| S. Carolina 2 | 2 | 4 |
| New Jersey 1 | 3 | 4 |
| New Jersey 2 | 1 | 0 |
| N. Carolina 1 | 3 | 2 |
| N. Carolina 2 | 3 | 3 |
| Total | 42 | 37 |

* Unit = One statement or comment by a single speaker.

participants believed that their annual reviews did not fully encompass reflection as it had been explained to them as part of *PD 2001* but was simply a management tool to be used by the organization rather than by the individual as a means of career planning.

**Study Question 4: Are participants aware of, or do their employers provide, any tools or techniques to assist with goal setting?**

This question had very little response. The only tool mentioned was the annual performance appraisal. The participants met this question with silence. Table 14 indicates that only six text units could be identified as relating to this question using the search words reflection, tools, techniques, employers, and assist/assistance with goal setting.

The groups that had text units on this topic did not have any identifiable trait to explain why they had this awareness while other groups did not. These groups did not have more managers than other groups or any other trait that stood out either from observation or from the data.

**Study Question 5: What are participants' priorities when considering five-year goals: schedule, pay, the opportunity to be self-directed, the opportunity to apply technical expertise, and/or job duties?**

On their questionnaires, the focus group participants were asked to rate each of these criteria on a five-point Likert scale. The scale was labeled with number one the equivalent of "not important" and number 5 the equivalent of "very important." Since the majority of the participants did not have goals, these criteria were more related to the activity of job selection rather than actually setting of formal goals. Although this

Table 14. Key word search results for "Are participants aware of, or do their employers provide, any tools or techniques to assist with goal setting?"

| State and group number | Units* related to the performance appraisal as a tool n |
|---|---|
| Oklahoma 1 | 1 |
| Oklahoma 2 | 0 |
| Texas 1 | 0 |
| Texas 2 | 1 |
| Indiana 1 | 0 |
| Indiana 2 | 0 |
| Missouri 1 | 0 |
| Missouri 2 | 0 |
| Minnesota 1 | 1 |
| Minnesota 2 | 0 |
| S. Carolina 1 | 0 |
| S. Carolina 2 | 0 |
| New Jersey 1 | 2 |
| New Jersey 2 | 1 |
| N. Carolina 1 | 0 |
| N. Carolina 2 | 0 |
| Total | 6 |

* Unit = One statement or comment by a single speaker.

question was not asked directly during the focus groups, some trends did emerge on this topic during the transcript analysis.

**Work Schedule**

Table 15 shows the responses from the questionnaire on the issue of work schedule. Ninety (68 %) of the 132 participants rated work schedule as number 4 or 5 on the Likert scale meaning it was a very important criteria to them when setting goals. Twenty-nine (22%) of the participants rated it as number three which was the mid-point of the scale. All groups were mixed in their responses but the lowest levels of importance for work schedule was noted in Missouri, South Carolina and New Jersey. Missouri was the only state to have a participant rate work schedule at the lowest level. The first group in South Carolina and the second group in New Jersey had a cluster of responses at level 2 on the Likert scale. The importance of work schedule may be related to urban versus rural workers or commuting time.

The focus group discussion revealed that childcare frustrations and the desire to be available for extracurricular school activities such as Girl Scouts and Little League were a concern for participants with children. This was found while searching for units related to family/child (Table 12). Several people voiced the hours of 4:30 PM or 5:00 PM as the time they need to switch gears and return their attention to their families. In one focus group, a participant remarked how difficult it was for her to handle crises that arose periodically at her healthcare facility and be on time to pick her children up from school. The other members of the group including those with grown children confirmed this sentiment. Several participants stated that they currently held part-time jobs because that allowed them more time with their family.

Table 15. Importance of "work schedule" in determining future career goals as reported on the questionnaire

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Important..... | | | | ..Very Important |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 0 | 12 | 22 | 44 | 22 |
| Oklahoma 2 | 7 | 0 | 0 | 43 | 43 | 14 |
| Texas 1 | 10 | 0 | 0 | 40 | 40 | 20 |
| Texas 2 | 9 | 0 | 0 | 23 | 44 | 33 |
| Indiana 1 | 7 | 0 | 0 | 14 | 29 | 57 |
| Indiana 2 | 7 | 0 | 14 | 14 | 58 | 14 |
| Missouri 1 | 10 | 10 | 10 | 10 | 50 | 20 |
| Missouri 2 | 8 | 0 | 0 | 25 | 63 | 12 |
| Minnesota 1 | 8 | 0 | 0 | 0 | 75 | 25 |
| Minnesota 2 | 8 | 0 | 0 | 38 | 12 | 50 |
| S. Carolina 1 | 8 | 0 | 38 | 12 | 25 | 25 |
| S. Carolina 2 | 9 | 0 | 12 | 22 | 22 | 44 |
| New Jersey 1 | 10 | 0 | 10 | 0 | 60 | 30 |
| New Jersey 2 | 8 | 0 | 37.5 | 37.5 | 0 | 25 |
| N. Carolina 1 | 7 | 0 | 14 | 14 | 14 | 58 |
| N. Carolina 2 | 7 | 0 | 0 | 43 | 43 | 14 |
| Total | 132 | 1 | 9 | 22 | 39 | 29 |

The focus groups allowed for a free-flow of ideas. This made it an excellent methodological choice for questions that had very complex answers. When discussing work schedule and its importance, a natural discussion arose about time and the many pressure and time constraints that plagued the participants. Participants often expressed the concern that the new requirements would take too much time. One participant stated that she was worried that this would become "one huge bureaucratic nightmare." Their schedules were overloaded and any new procedures were looked at suspiciously partly because of this concern for their personal time. The statement "I don't have time" was searched for in the transcripts and was often followed by comments such as "to go back to school", "to attend far-away meetings", "to deal with this", "to worry about this" and other similar sentiments. There was a strong message that future goals would surely be influenced by the time commitment necessary to reach those goals. This type of personal revelation could only have come during the heated and passionate discussions of the focus groups and was not evident on the questionnaire.

**The Importance of Pay**

Table 16 shows the responses to the influence of pay on participants' goals and job selection as reported on the questionnaire. Ninety-one (68%) rated pay as number 4 and 5 on the five-point scale indicating that this was another important issue to them. Thirty-six (27%) rated pay at the mid-point of the scale (number 3). There was not a single response at the lowest level of priority. Only five responses were given at level two. These were in the states of Indiana, Missouri, and one participant in New Jersey. One possible explanation may be that the cost of living in Indiana and Missouri may be lower than elsewhere but this does not account for New Jersey.

Table 16. Importance of "pay" in determining future career goals as reported on the questionnaire

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Important..... | | | | .....Very Important |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 0 | 0 | 11 | 67 | 22 |
| Oklahoma 2 | 7 | 0 | 0 | 43 | 14 | 43 |
| Texas 1 | 10 | 0 | 0 | 30 | 30 | 40 |
| Texas 2 | 9 | 0 | 0 | 33 | 44 | 23 |
| Indiana 1 | 7 | 0 | 13 | 29 | 29 | 29 |
| Indiana 2 | 7 | 0 | 28.5 | 43 | 0 | 28.5 |
| Missouri 1 | 10 | 0 | 10 | 20 | 50 | 20 |
| Missouri 2 | 8 | 0 | 0 | 50 | 50 | 0 |
| Minnesota 1 | 8 | 0 | 0 | 25 | 63 | 12 |
| Minnesota 2 | 8 | 0 | 0 | 25 | 63 | 12 |
| S. Carolina 1 | 8 | 0 | 0 | 25 | 37.5 | 37.5 |
| S. Carolina 2 | 9 | 0 | 0 | 33.3 | 33.3 | 33.3 |
| New Jersey 1 | 10 | 0 | 10 | 20 | 50 | 20 |
| New Jersey 2 | 8 | 0 | 0 | 25 | 75 | 0 |
| N. Carolina 1 | 7 | 0 | 0 | 14 | 72 | 14 |
| N. Carolina 2 | 7 | 0 | 0 | 14 | 43 | 43 |
| Total | 132 | 0 | 4 | 27 | 45 | 24 |

During the group discussions, pay was a volatile issue. Again, the focus group methodology allowed for expression of deeply held beliefs with the accompanying angry body language observed by the researcher. The participants who discussed pay strongly and clearly voiced their opinion that they do not feel that the pay for the profession of dietetics commensurates with the level of education and knowledge most dietitians possess. The groups were very eager to discuss this issue but debating the reasons for the low-level pay was not the purpose of the focus groups so the moderator redirected the groups after allowing short discussions on this issue. The most discussion was in the first group in New Jersey where one participant was almost hysterical about the pay and had to be asked to turn her attention to another topic.

Two distinct lines of thinking about pay were revealed during the focus group discussions. The transcripts were searched for key words that included pay, salary, entrepreneur, and negotiate. Table 17 shows the search results related to the issue of pay being too low and the rebuttal to negotiate your own pay. Thirty-eight comments were made about pay being too low while 20 comments were heard that said each individual should negotiate his or her own situation. Many of these comments are attributed to the first New Jersey group that had extensive discussion on this topic due to one individual that was quickly redirected by the researcher once she got off track.

Some participants felt that each individual needed to assertively negotiate a reasonable wage for himself or herself. The people who voiced this idea usually prefaced their comments by saying that they were in consulting or private practice or had ventured beyond the traditional dietetics job. Their main idea was to make your own

Table 17. Key word search results for issues related to the pay scale of dietitians

| State and group number | Units* related to pay being too low n | Units* related to entrepreneurs/negotiating your own pay n |
|---|---|---|
| Oklahoma 1 | 0 | 0 |
| Oklahoma 2 | 1 | 0 |
| Texas 1 | 2 | 3 |
| Texas 2 | 3 | 4 |
| Indiana 1 | 0 | 1 |
| Indiana 2 | 3 | 0 |
| Missouri 1 | 2 | 0 |
| Missouri 2 | 2 | 0 |
| Minnesota 1 | 3 | 0 |
| Minnesota 2 | 3 | 2 |
| S. Carolina 1 | 1 | 0 |
| S. Carolina 2 | 0 | 0 |
| New Jersey 1 | 10 | 8 |
| New Jersey 2 | 3 | 2 |
| N. Carolina 1 | 2 | 0 |
| N. Carolina 2 | 3 | 0 |
| Total | 38 | 20 |

* Unit = One statement or comment by a single speaker.

opportunities. For example, one participant had combined dietetics with her background in communications while several said they had ventured into sales. The researcher observed that the notion of taking charge of your own career was met by deep sighs and even hostility by many people who felt it could not be done. One woman in New Jersey summed it up best by saying, "You are working, you have family, you have children, plus you do volunteer work, but nobody wants to give you any money. So all these years we studied, studied and did so much work and continuing education and we pay a lot to become members but nobody pays us." This statement represented the second line of thinking which was that the problem of low pay is much larger than the individual dietitian and needed to be addressed by the profession as a whole. The groups would have been willing to debate pay for the entire session but they were redirected away from this issue.

**The opportunity to be self-directed and make independent decisions**

Table 18 shows the responses to the question of self-direction and the opportunity to make independent decisions as reported on the questionnaire. Seventy-five (57%) of the participants gave this item the highest ranking, number 5 on the five-point scale. An additional 47 (36%) participants ranked it at number 4 and 10 (7.6%) participants ranked it at number 3. No responses in any group were given at the number 1 or 2 level clearly indicating that this was an important issue to all participants. This topic did not appear in the transcripts of the focus groups.

**The opportunity to apply technical expertise**

Closely related to this issue is the opportunity to apply technical expertise which was the next factor to be ranked on the questionnaire. Ninety-six participants ranked this

Table 18. Importance of "the opportunity to be self-directed and make independent decisions" in determining future career goals as reported on the questionnaire

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Important..... | | | | ...Very Important |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 0 | 0 | 0 | 44 | 56 |
| Oklahoma 2 | 7 | 0 | 0 | 29 | 14 | 57 |
| Texas 1 | 10 | 0 | 0 | 0 | 50 | 50 |
| Texas 2 | 9 | 0 | 0 | 12 | 22 | 66 |
| Indiana 1 | 7 | 0 | 0 | 14 | 29 | 57 |
| Indiana 2 | 7 | 0 | 0 | 0 | 43 | 57 |
| Missouri 1 | 10 | 0 | 0 | 10 | 40 | 50 |
| Missouri 2 | 8 | 0 | 0 | 0 | 37.5 | 62.5 |
| Minnesota 1 | 8 | 0 | 0 | 0 | 50 | 50 |
| Minnesota 2 | 8 | 0 | 0 | 12 | 38 | 50 |
| S. Carolina 1 | 8 | 0 | 0 | 0 | 12 | 88 |
| S. Carolina 2 | 9 | 0 | 0 | 33 | 23 | 44 |
| New Jersey 1 | 10 | 0 | 0 | 0 | 50 | 50 |
| New Jersey 2 | 8 | 0 | 0 | 0 | 50 | 50 |
| N. Carolina 1 | 7 | 0 | 0 | 0 | 0 | 100 |
| N. Carolina 2 | 7 | 0 | 0 | 14 | 57 | 29 |
| Total | 132 | 0 | 0 | 7 | 36 | 57 |

Table 19. Importance of "the opportunity to apply technical expertise" in determining future career goals as reported on the questionnaire

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Important..... | | | | .....Very Important |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 0 | 0 | 12 | 44 | 44 |
| Oklahoma 2 | 7 | 14 | 0 | 57 | 0 | 29 |
| Texas 1 | 10 | 0 | 0 | 20 | 50 | 30 |
| Texas 2 | 9 | 0 | 22 | 22 | 34 | 22 |
| Indiana 1 | 7 | 0 | 0 | 14 | 72 | 14 |
| Indiana 2 | 7 | 0 | 0 | 0 | 72 | 28 |
| Missouri 1 | 10 | 0 | 0 | 40 | 50 | 10 |
| Missouri 2 | 8 | 0 | 0 | 25 | 38 | 38 |
| Minnesota 1 | 8 | 0 | 0 | 12 | 38 | 50 |
| Minnesota 2 | 8 | 0 | 0 | 37.5 | 62.5 | 0 |
| S. Carolina 1 | 8 | 0 | 0 | 25 | 12 | 63 |
| S. Carolina 2 | 9 | 0 | 0 | 56 | 44 | 0 |
| New Jersey 1 | 10 | 0 | 0 | 30 | 40 | 30 |
| New Jersey 2 | 8 | 0 | 0 | 25 | 37.5 | 37.5 |
| N. Carolina 1 | 7 | 0 | 0 | 14 | 57 | 29 |
| N. Carolina 2 | 7 | 0 | 0 | 0 | 57 | 43 |
| Total | 132 | 1 | 1 | 25 | 44 | 29 |

factor as number 4 or 5 on the five-point scale (Table 19). Additionally, 33 (25%) ranked this factor as number 3 on the scale with only a total of 3 people ranking it in categories 1 or 2 – one person in Oklahoma and two people in Texas.

Review of the focus group transcripts showed that the participants wanted to be respected as the nutrition experts. They expressed fear that other professions were moving into their territory and wondered where that would leave them. Nurses, pharmacists, doctors, and even social workers were all mentioned as threats to the nutrition professional. There was extensive debate on the topic of specialization versus the generalist dietitian. This issue was raised in every focus group because of the participants' belief that *PD 2001* was going to mandate specialization for all dietitians. Some people believed that *PD 2001* would only allow goals in one area while others believed that the sole purpose of *PD 2001* was to create more specialists. Table 20 shows the transcript search results for the key words generalist, specialist, specialization, and nutrition expert. Every group discussed this topic in some form. Again, there was heated discussion for both generalist and specialist. Many of the participants debated with each other which revealed deeply personal information. Focus groups clearly was the best methodology to provide the forum for the participants to debate back and forth and show their true feelings and emotional involvement with the topic.

Review of the transcript search results in the context in which the original statements were made showed that the argument for generalists was based on the belief that to remain viable in today's healthcare environment, a dietitian must know something about all topics. Three participants said that they worked for health maintenance organizations

Table 20. Key word search results for issues related to the opportunity to apply technical expertise

| State and group number | Units* related to being a specialist n | Units* related to being a generalist n |
|---|---|---|
| Oklahoma 1 | 4 | 5 |
| Oklahoma 2 | 5 | 6 |
| Texas 1 | 3 | 5 |
| Texas 2 | 5 | 4 |
| Indiana 1 | 7 | 4 |
| Indiana 2 | 4 | 4 |
| Missouri 1 | 3 | 4 |
| Missouri 2 | 5 | 4 |
| Minnesota 1 | 8 | 5 |
| Minnesota 2 | 4 | 2 |
| S. Carolina 1 | 1 | 3 |
| S. Carolina 2 | 6 | 5 |
| New Jersey 1 | 3 | 3 |
| New Jersey 2 | 6 | 7 |
| N. Carolina 1 | 6 | 5 |
| N. Carolina 2 | 5 | 6 |
| Total | 75 | 72 |

* Unit = One statement or comment by a single speaker.

(HMO) and needed to be able to speak to people with various medical conditions. Others cited the declining numbers of hospital-based dietitians and the fact that those remaining had to see more patients. For example, one participant identified herself as a renal dietitian. She continued to say that the staff at her facility was down-sized and now she was the renal and the diabetic dietitian and even had to cover pediatrics if someone called in sick. This sentiment was voiced over and over.

The issue of students was woven in the discussion. Most participants agreed that when they were students they were not able to definitively state what area of the profession they wanted to work in upon graduation. Several believed they knew but changed their minds as they were exposed to other opportunities during their clinical practicums or internships. Several people stated that they imagined most students were unaware of the vast possibilities that exist in this profession. In fact, the wide variety of jobs was often mentioned as one of the positive aspects of the profession. Most participants expressed concern that if *PD 2001* "forced students to specialize, they would be unprepared for many jobs."

There were almost an equal number of comments on specialization but as a whole the groups favored generalization. Those in support of specialization felt that in a field as young and as varied as dietetics, it was impossible to keep up on all topics. Herbology and alternate medicine were frequently mentioned as new and interesting topics that have only recently become a part of the dietitians' knowledge bank. A diabetes educator stated that she can hardly keep up with the changes in the diabetes field much less learn about herbs. Again, the issue of time was a concern. She continued that if she has time to read one article, it is going to be on diabetes and things she needs to know for her

immediate job rather than something that may be interesting but that will not help her keep her job.

**Variety of Job Duties**

Table 21 outlines the responses to the importance of having a variety of job duties as reported on the questionnaire. One hundred and four (79%) participants ranked this as number 4 and 5 on the five-point scale. Twenty-one (16%) ranked it as number 3.

The discussion during the focus groups indicated that the variety of jobs available was an attraction to the profession as a whole. The favoring of a generalist dietitian also confirms that the participants preferred to work in many areas rather than be limited in scope of practice. On three occasions, participants commented that by simply saying to friends or family "I am a Registered Dietitian", they are bombarded with questions ranging from advice for vitamin supplementation to weight loss questions. It was generally believed that if you are going to promote yourself as an RD, you must be able to answer questions on a wide-variety of topics. To the participants, this meant that they preferred to do different things each day and experience different facets of the profession. This was clearly voiced by consultants who were very pleased that they were able to plan their own activities and visit different facilities.

**Study Question 6: What are the attitudes of the participants towards *PD 2001*?**

The focus groups were not asked to report on their attitude directly. There weren't any probing questions that asked them to state their attitude. However, by using the focus group methodology, their attitudes were revealed in a way that would not have been possible using any other traditional research methods.

The first finding on attitudes was based on researcher observation. It was noted that

Table 21. Importance of "variety of job duties" in determining future career goals as reported on the questionnaire

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not Important..... | | | | .....Very Important |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 0 | 11 | 11 | 56 | 22 |
| Oklahoma 2 | 7 | 13 | 0 | 29 | 29 | 29 |
| Texas 1 | 10 | 0 | 10 | 30 | 60 | 0 |
| Texas 2 | 9 | 0 | 0 | 33 | 23 | 44 |
| Indiana 1 | 7 | 0 | 0 | 14 | 43 | 43 |
| Indiana 2 | 7 | 0 | 14 | 14 | 43 | 29 |
| Missouri 1 | 10 | 0 | 10 | 10 | 50 | 30 |
| Missouri 2 | 8 | 0 | 0 | 12 | 38 | 50 |
| Minnesota 1 | 8 | 0 | 0 | 12 | 25 | 63 |
| Minnesota 2 | 8 | 0 | 0 | 0 | 37.5 | 62.5 |
| S. Carolina 1 | 8 | 0 | 0 | 0 | 62.5 | 37.5 |
| S. Carolina 2 | 9 | 0 | 12 | 33 | 22 | 33 |
| New Jersey 1 | 10 | 0 | 10 | 30 | 40 | 20 |
| New Jersey 2 | 8 | 0 | 0 | 0 | 62.5 | 37.5 |
| N. Carolina 1 | 7 | 0 | 0 | 14 | 43 | 43 |
| N. Carolina 2 | 7 | 0 | 0 | 0 | 71 | 29 |
| Total | 132 | 1 | 4 | 16 | 44 | 35 |

the participants were eager to discuss this topic. In fact, several expressed relief with statements such as "finally we have someone to listen", "can you tell me what is going on?" and "I need to know what to tell our members so I am glad to discuss this." The researcher noted that opinions were strong and that the participants were looking for an outlet for these opinions.

The attitudes of participants towards *PD 2001* ran the gamut from open hostility to welcoming change. Each group contained participants that represented both points of view. Several groups even had impassioned discussions among themselves because of these two distinct opinions. The attitudes of the participants represented every point along the continuum from openly campaigning against *PD 2001* to indifference to feeling positive.

Hostility was defined by loud, impassioned negative comments voiced with the corresponding body language. Those who were openly hostile believed that ADA was treating members as children and had no right to "approve or disapprove" their goals. There were negative comments heard in every focus group. One Texas participant summed it up by saying, "I don't like the Big Brother concept, I am sorry." A dietitian from Kansas City said, "We pay our dues and meet their requirements for registration and maintenance and such, and then they go and change the system without even talking to us members at large." In Oklahoma a participant stated, "I believe the problem is how the initial information got out to us. I don't believe it was presented as it was intended and there was miscommunication." A participant in Texas voiced a sentiment that was heard repeatedly throughout the groups: "I guess I am missing the point – so if you complete

these forms perfectly and have a great plan, how does that assure that you are competent?"

The perceived lack of explanation for the reason behind the change appeared to be the basis for many of the negative attitudes. Table 22 shows the transcript search results for text units related to the uncertain reason or impetus for the change to a new system. Search words included beneficiary, benefit, new system, change, and CDR. A total of 266 text units were found. This topic was a considerable portion of the discussion in each group.

The participants were extremely unclear as to who the intended beneficiary of the new system is supposed to be. The participants were asked to discuss if they believed that their patients would benefit. The participants did not see any connection between better care and the portfolio model of recertification. Most individuals who commented did not see this link even after the focus group leader suggested that targeted CE would improve knowledge and thus lead to better care.

One repeated comment was that the clinicians who kept abreast of changes and new information would continue to do so and *PD 2001* would not change those who did not. As one New Jersey dietitian stated, "*PD 2001* cannot change human nature." Overall, the negative comments and feelings of uncertainty dominated the discussions.

The focus groups provided the setting to probe even further and look at several possible reasons for the negative attitudes. The remainder of the study questions determined what influenced these attitudes.

**Study Question 7: Did attendance at lectures, delegate reports, or CDR written materials influence the attitude towards *PD 2001*?**

Table 22. Key word search results indicating uncertainty about the reason or impetus for changing to a new credentialing system

| State and group number | Units* related to the unclear reason for changing systems n |
|---|---|
| Oklahoma 1 | 12 |
| Oklahoma 2 | 15 |
| Texas 1 | 16 |
| Texas 2 | 21 |
| Indiana 1 | 16 |
| Indiana 2 | 17 |
| Missouri 1 | 12 |
| Missouri 2 | 15 |
| Minnesota 1 | 23 |
| Minnesota 2 | 19 |
| S. Carolina 1 | 15 |
| S. Carolina 2 | 16 |
| New Jersey 1 | 22 |
| New Jersey 2 | 19 |
| N. Carolina 1 | 15 |
| N. Carolina 2 | 13 |
| Total | 266 |

* Unit = One statement or comment by a single speaker.

Table 23 indicates that exactly half of the 132 participants had attended delegate sessions or other lectures on *PD 2001* while the other half did not. This question was asked on the questionnaire. There did not appear to be any pattern to explain which groups attended and which did not. For example, the highest level of attendance of any group (80%) was the first group in New Jersey. This is in contrast to the fact that the lowest attendance of any group (0%) was the second group in New Jersey. The New Jersey focus group attendees were solicited using a sign-up sheet at the registration table and was totally random. The other groups had mixed attendance rates and did not show any pattern.

The questionnaire data was expanded upon in the focus groups although there was no probing question that asked specifically about attendance at information sessions on *PD 2001*. However, review of the transcripts showed that many of the people who had negative comments also had not attended any delegate sessions on *PD 2001* and had not read the printed matter. This is known because they prefaced their comments with qualifiers such as "I haven't attended any of the delegate reports" or "I only skimmed the printed information but my feeling is..."

This was balanced by comments that began with "At the lecture I went to, they said..." Most of these types of comments showed a greater understanding of the program with more accuracy. Individuals in two groups made comments that they had attended a session on the topic but that the *speaker* was unclear about the requirements. Three comments were made in three different groups that the speakers were not even in favor of the change and had presented the lecture with a negative slant.

Table 23. Attendance at lectures and/or delegate reports on *PD 2001*

| State and group number | n | % Responses Yes | No |
|---|---|---|---|
| Oklahoma 1 | 9 | 33 | 67 |
| Oklahoma 2 | 7 | 29 | 71 |
| Texas 1 | 10 | 90 | 10 |
| Texas 2 | 9 | 89 | 11 |
| Indiana 1 | 7 | 57 | 43 |
| Indiana 2 | 7 | 43 | 57 |
| Missouri 1 | 10 | 30 | 70 |
| Missouri 2 | 8 | 50 | 50 |
| Minnesota 1 | 8 | 50 | 50 |
| Minnesota 2 | 8 | 37 | 63 |
| S. Carolina 1 | 8 | 37 | 63 |
| S. Carolina 2 | 9 | 22 | 78 |
| New Jersey 1 | 10 | 20 | 80 |
| New Jersey 2 | 8 | 100 | 0 |
| N. Carolina 1 | 7 | 57 | 43 |
| N. Carolina 2 | 7 | 57 | 43 |
| Total | 132 | 50 | 50 |

It appears that attendance at a lecture or delegate report would be beneficial in assisting with the understanding of the new program. Care should be taken to have well-trained and positive speakers for maximum benefit.

Table 24 shows that 36 participants (28%) believed they had read the CDR printed materials on *PD 2001* thoroughly and rated it 4 or 5 on a five-point Likert scale on the questionnaire. The majority, 70 participants, 53 percent, rated it number 3 which was labeled "skimmed." The remaining 20 percent, 26 participants, had not read the materials.

As stated previously, the states of Indiana, Minnesota, and North Carolina recruited focus groups participants from their administrative councils. The researcher theorized that these groups would have a large percentage of members who thoroughly read the materials. Since these were the leaders of the state and local dietetic associations, it seems that they would have spent more time becoming acquainted with the new program. The questionnaire data did not support this theory as these groups had a very low percentage of people who reported they had thoroughly read the materials. In Indiana, only one person rated the reading of CDR materials at level 5 (thoroughly read). In Minnesota, there were none and in North Carolina, there was one person.

The focus group transcripts did not contain many comments related to the printed materials. Six text units were found that directly related to people questioning if in fact they had received any printed materials at all. Two people insisted that they never received anything even after being told that three separate mailings were made to all credentialed practitioners.

Table 24. Reading of the CDR materials on *PD 2001*

| State and group number | n | % Responses | | | | |
|---|---|---|---|---|---|---|
| | | Not read..... | | .....Skimmed..... | | .....Read thoroughly |
| | | 1 | 2 | 3 | 4 | 5 |
| Oklahoma 1 | 9 | 11 | 11 | 67 | 11 | 0 |
| Oklahoma 2 | 7 | 43 | 14 | 43 | 0 | 0 |
| Texas 1 | 10 | 10 | 20 | 40 | 10 | 20 |
| Texas 2 | 9 | 0 | 11 | 67 | 0 | 22 |
| Indiana 1 | 7 | 14 | 0 | 58 | 14 | 14 |
| Indiana 2 | 7 | 0 | 14 | 43 | 43 | 0 |
| Missouri 1 | 10 | 40 | 0 | 50 | 10 | 0 |
| Missouri 2 | 8 | 0 | 12 | 38 | 25 | 25 |
| Minnesota 1 | 8 | 13 | 0 | 74 | 13 | 0 |
| Minnesota 2 | 8 | 0 | 0 | 100 | 0 | 0 |
| S. Carolina 1 | 8 | 25 | 12.5 | 50 | 12.5 | 0 |
| S. Carolina 2 | 9 | 11 | 11 | 23 | 44 | 11 |
| New Jersey 1 | 10 | 10 | 0 | 70 | 10 | 10 |
| New Jersey 2 | 8 | 12 | 0 | 50 | 38 | 0 |
| N. Carolina 1 | 7 | 14 | 0 | 43 | 29 | 14 |
| N. Carolina 2 | 7 | 0 | 0 | 29 | 71 | 0 |
| Total | 132 | 12 | 7 | 53 | 20 | 8 |

**Study Question 8: Are the attitudes towards *PD 2001* based on accurate knowledge of the requirements of *PD 2001*?**

During the focus group discussion, the researcher heard many inaccurate comments from the participants. The participants held many erroneous beliefs about what will be required. Even those who had attended delegate sessions had erroneous beliefs and several participants stated that the speaker at the session they attended was not clear about the requirements.

Table 25 shows the research results for the three major areas that were found to be inaccurate based on review of the transcripts. These inaccurate beliefs were 1) That CDR must approve all learning plans, 2) That there will be a membership vote to determine if the new plan is instituted, and 3) That the self-monitoring aspect of the new plan invites cheating.

The most common misconception was that CDR would read each five-year plan and then send a letter stating that it was either approved or disapproved. The moderator corrected their errors and informed them that each individual is going to monitor his or her own plan and CDR will simply verify that the requirements have been met.

This led to conjecture that such a plan would lead to cheating and "fancy paperwork." The theme of dishonesty ran through every focus group. This showed that participants did not have the basic understanding of the plan or the principles on which it was based. The participants were extremely worried that they would be working hard while others would be getting away with cheating. In Texas a participant stated, "I really see them being able to cheat on this. This is a much bigger avenue for them to cheat than the way

Table 25. Key word search results for misinformation related to *PD 2001*

| State and group number | Units* related to CDR must approve the learning plan n | Units* related voting in the the new system n | Units* related concern over cheating n |
|---|---|---|---|
| Oklahoma 1 | 2 | 3 | 5 |
| Oklahoma 2 | 1 | 0 | 6 |
| Texas 1 | 2 | 0 | 3 |
| Texas 2 | 0 | 0 | 4 |
| Indiana 1 | 3 | 0 | 4 |
| Indiana 2 | 1 | 0 | 4 |
| Missouri 1 | 3 | 4 | 6 |
| Missouri 2 | 0 | 0 | 3 |
| Minnesota 1 | 3 | 0 | 4 |
| Minnesota 2 | 2 | 0 | 4 |
| S. Carolina 1 | 4 | 4 | 5 |
| S. Carolina 2 | 0 | 0 | 3 |
| New Jersey 1 | 5 | 2 | 7 |
| New Jersey 2 | 3 | 0 | 4 |
| N. Carolina 1 | 1 | 0 | 3 |
| N. Carolina 2 | 3 | 0 | 3 |
| Total | 33 | 13 | 68 |

* Unit = One statement or comment by a single speaker.

we are doing it now." In North Carolina, a participant said, "I know people cheat nowadays but I think it is going to be easier." These comments represented the general thinking that the self-evaluation of goals would make it quite easy for the less ethical people to be dishonest. A rationale offered by a few participants was that the people who cheat now will continue to cheat under any system and that these people are hopefully, the minority.

In four focus groups it was believed that the focus group discussion was simply an exercise because the membership would not vote to approve the new requirements. When corrected that there was not going to be a vote, these members were very surprised and wondered how the rules can change without a vote.

Another inaccuracy that was brought up in three groups was that people would lose their credential as a result of having their plans rejected or if all the goals were not met at the end of five years. This belief was further interpreted to mean that in order to assure continued credentialing, it would be wise to make very low level and easy-to-achieve goals. Again, this misinformation indicated that there was a lack of the basic premise of *PD 2001* and its purpose. If setting low level goals becomes a wide-spread practice, *PD 2001* will not effect any change and may be detrimental to the profession.

*Professional Development 2001* has undergone many revisions and this appeared to further confuse the participants. There were comments that the participants had looked at the printed material when it was first mailed to practitioners but they did not read the updates. Due to practitioner feedback, CDR modified the requirements in subsequent drafts of *PD 2001*, but many people held on to their first impressions. During each focus

group, the focus group moderator stated that we would be discussing Version 4 of *PD 2001*. This statement was met with confusion because many participants were unaware of the three previous drafts.

Several participants did have a good working knowledge of the new requirements. One participant from Minnesota stated that she was an ADA delegate and had given presentations on this topic to her constituents. Researcher observation showed that the participants with accurate information did not have the anger towards CDR and ADA that many others expressed. These people corrected their colleagues during the focus groups and there was considerable interaction between those who had the information and those who had misinformation during the focus groups.

The transcripts showed several comments beginning "I'm not sure but I heard..." or "Tell me if this is true but I heard..." This showed that even the participants who believed they were informed were not absolutely certain of the requirements and were seeking validation of their beliefs. The participants with the correct information were more focused on the implementation process and how it would affect the profession in the years to come.

The major theme that was repeated by all groups was that the participants did not see any connection between *PD 2001* and a positive change for the profession. Again, the question of the intended beneficiary troubled the participants. The focus groups were asked if they believed that there would be a better profession as a result of *PD 2001*. Each group felt that patients would be unaware of the change and that it would not impact the level of the profession in the eyes of the patients. The groups were then asked to imagine the future with all credentialed dietitians working towards their goals in an

orderly fashion and if this would improve the situation. After thinking about *PD 2001* as a whole, rather than simply paperwork, most participants stated that it may improve the profession. Participants were so concerned about the amount of paperwork and the logistics of implementation that it was very difficult for them to look beyond these points.

**Study Question 9: Does being an active participant in a state or district dietetic association influence the attitude towards *PD 2001*?**

This question was not asked directly in the focus groups but the researcher was able to observe that those people who were active tended to have a better acceptance of the change. Although they did not necessarily have a more accurate understanding of the true requirements, they did understand that the change was imminent. As shown previously (Table 23), the groups with very active members did not read the printed matter more thoroughly than any other group so this may explain their lack of knowledge.

To complement the focus groups, the questionnaire data was used to determine if the participants who had attended lectures and/or delegate reports were the dietitians who were very involved in their district and/or state dietetic associations. Table 26 shows the level of involvement in district and/or state dietetic associations classified by attendance at a previous session on *PD 2001*. The actively involved people who rated themselves at the highest level of involvement also had the highest level of attendance at a lecture or delegate report with 66.6 percent having attended.

Table 26. Percentage of participants having attended lectures and/or delegate reports classified by level of involvement in district and/or state dietetic associations

| | % Responses | | | | |
|---|---|---|---|---|---|
| | Level of Involvement | | | | |
| | Not involved.....Actively involved | | | | |
| | 1<br>n=14 | 2<br>n=23 | 3<br>n=25 | 4<br>n=19 | 5<br>n=51 |
| Attended lecture and/or delegate report | 50 | 39.1 | 36 | 36.9 | 66.7 |
| Did not attend lecture and/or delegate report | 50 | 60.9 | 64 | 63.1 | 33.3 |
| Total | 100 | 100 | 100 | 100 | 100 |

**Study Questions 10: Does previous exposure to a similar portfolio method influence the attitude towards *PD 2001*?**

Participants were asked if they had experience with requirements similar to *PD 2001*. Table 27 shows that 123 participants, 93 percent, did not have experience with anything similar to *PD 2001* in the past. Nine people representing 7 percent of the participants reported that they did have experience with a similar program. Three people made

Table 27. Has previous experience with requirements similar to *PD 2001*

| State and group number | n | % Responses Yes | No |
|---|---|---|---|
| Oklahoma 1 | 9 | 11 | 89 |
| Oklahoma 2 | 7 | 0 | 100 |
| Texas 1 | 10 | 10 | 90 |
| Texas 2 | 9 | 11 | 89 |
| Indiana 1 | 7 | 0 | 100 |
| Indiana 2 | 7 | 14 | 86 |
| Missouri 1 | 10 | 0 | 100 |
| Missouri 2 | 8 | 0 | 100 |
| Minnesota 1 | 8 | 13 | 87 |
| Minnesota 2 | 8 | 13 | 87 |
| S. Carolina 1 | 8 | 0 | 100 |
| S. Carolina 2 | 9 | 11 | 89 |
| New Jersey 1 | 10 | 0 | 100 |
| New Jersey 2 | 8 | 13 | 87 |
| N. Carolina 1 | 7 | 14 | 86 |
| N. Carolina 2 | 7 | 0 | 100 |
| Total | 132 | 7 | 93 |

comments that related to having been required to set goals when they worked in a profession other than dietetics. Three others stated that their experience was due to a spouse or significant other.

**Study Question 11: Do number of years in practice influence the attitude towards *PD 2001*?**

The number of years in practice did influence the attitude towards *PD 2001*. The responses appeared to fall into three categories. The participants who were newly credentialed or were on their first five-year credentialing period voiced the most accepting attitude. The second group that emerged was those who had been in the field for two or three credentialing periods and were accustomed to the old methods. The third group was people who identified themselves as being near retirement and often stated that they had been in the field greater than twenty years. Two people mentioned being "grandfathered" in to the profession and fondly reminisced about the "good old days." To determine how many participants were in which stage of their career, the questionnaire data was tabulated for these three major career stages. Table 28 shows that the majority of the participants were in the middle of their careers with 71 participants (53.8%) having between six and nineteen years of experience. Twenty-six people, 19.7 percent, were in their first credentialing period while 35 people (26.5%) had over twenty years of experience and were anticipating retirement.

The participants with over twenty years of practice did not favor the change to *PD 2001* because they did not want to be bothered with a new system when they may only be working for a few more years. One participant in Indiana stated that it was her husband who was close to retirement and that they would have to work her goals into the family

Table 28. Number of years in practice

| Number of years in practice | n | % |
|---|---|---|
| 1 – 5 years | 26 | 19.7 |
| 6 – 19 years | 71 | 53.8 |
| Over 20 years | 35 | 26.5 |
| Total | 132 | 100 |

master plan. Another Indiana participant stated that she was close to retirement and that she "didn't want to get a whole new career thing going at this time." In South Carolina, one participant stated that she was grandfathered in by CDR and "this whole thing is not practical for those in my age category; my five-year goal is to be 90 percent retired." In Texas, it was questioned "what about those people close to retirement who have already met their goals?" These and similar responses indicate that those nearing retirement have different concerns than other groups.

The attitude of those nearing retirement was less favorable than the attitude of dietitians who were just starting their careers. The people just beginning their careers seemed to be the most accepting and did not voice many comments. One participant in Missouri stated that it was her first year practicing as an RD and she wasn't even sure about the current system so she may as well learn about the new system. This type of response represented the participants in the five-or-less years in practice category. Those who commented were most accepting of the change. Only six text units throughout all

groups could be positively identified as having come from people early in their career and expressed an accepting attitude.

The most impassioned responses came from people who had worked for many years under the old system but still had many years left to work under the new system. The main comment from this group was a lack of clarity concerning the reason why a change was necessary at all. Participants made almost identical comments asking what was wrong with the old system. One Indiana participant summed it up by saying "if it ain't broke, don't fix it."

**Study Question 12: Does area of practice (clinical, management, community, or education) influence the attitude towards *PD 2001*?**

Researcher observation indicated that people in the management area were more accepting of the new program because they were most comfortable with setting goals in general. Since this question was not asked directly in the focus groups a review of the transcripts for key words goals, goal setting, and each of the practice areas appearing together was done. Seven text units fitting this pattern were found representing the states of Minnesota, Missouri, and Texas. The comments all represented the management area. One comment was that the department managers are usually responsible for assuring that their employees' complete annual self- assessments and many of these assessments include goal setting for the next year. The other comments concurred that being in management gave them more exposure to goal setting. It may be that this exposure to one of the key components of *PD 2001* alleviates some of the fear.

No other patterns were noted to indicate if one practice area had a better overall attitude than the others did.

**Discussion**

The dual methodological design of this study provided two different types of information, both of which served its purpose. The questionnaire data was useful in helping to generate numbers to quantify various characteristics of the participants. For example, it was useful to have the exact number of participants who had attended a prior session on *PD 2001* because those sessions clearly influenced their attitude toward the new system. It was also helpful to find out precisely how many participants worked in each area of practice and how many years they worked as an RD. Numerical data was best collected by the questionnaire and provided quantitative data to add support to the study. The questionnaire also helped to formally begin each focus group session. By administering the questionnaire, the researcher was able to clearly begin the research session and quiet all the participants and bring their attention to the matter at hand. The questionnaires were all properly completed and no problems were encountered with the questionnaire.

The focus group discussion provided the insightful, emotional data that could not have been collected on a questionnaire. Every single focus group was lively, interesting, and informative – not only for the researcher but for the participants as well. Many compliments were received on how useful and instructive the participants felt the focus groups were and how they were glad they had participated. The weakness of the focus groups is the ease with which the discussion can stray from the research topic. The researcher must listen carefully to each word and keep the discussion on track without being rude to the participants. The researcher was able to accomplish this by clearly stating the questions and not letting conversation stray too far from the topic. Each time

discussion was moving away from the desired topic, the researcher interceded and restated the topic. If data on highly personal and emotional issues is desired, focus groups are ideal.

The two methods taken together provided a vast amount of data that clearly identified a communication gap between CDR and the dietitians. The question of why the credentialing process is changing, who benefits, and why a portfolio model was chosen all seemed to be lingering questions in the minds of the participants. To assure a successful transition, it is imperative that these major issues be addressed in a clear manner by CDR.

Figure 2 shows the revised process model based on the answers to the study questions. The preliminary model was reviewed and evaluated based on participant input and what was learned about where they are currently in the process, their attitude towards the process, and their concerns and fears. The process model takes into account what was learned from the focus groups and the questionnaire. It can be used as a guide for practitioners as they begin to design their lifelong learning portfolios.

The process model defines the focus group participants' views on how the credentialing change will affect them as individuals and how it will affect the profession as a whole. The first level to be impacted is the individual. The targeted continuing education that will be required by *PD 2001* will have the most immediate impact on the individual RD. By virtue of having had a positive, applicable, targeted learning experience, the RD will be better able to treat patients or function in their job. This means better patient outcomes and more effective delivery of dietetic services. This is crucial for protecting the public. A side benefit may be better pay in the future because

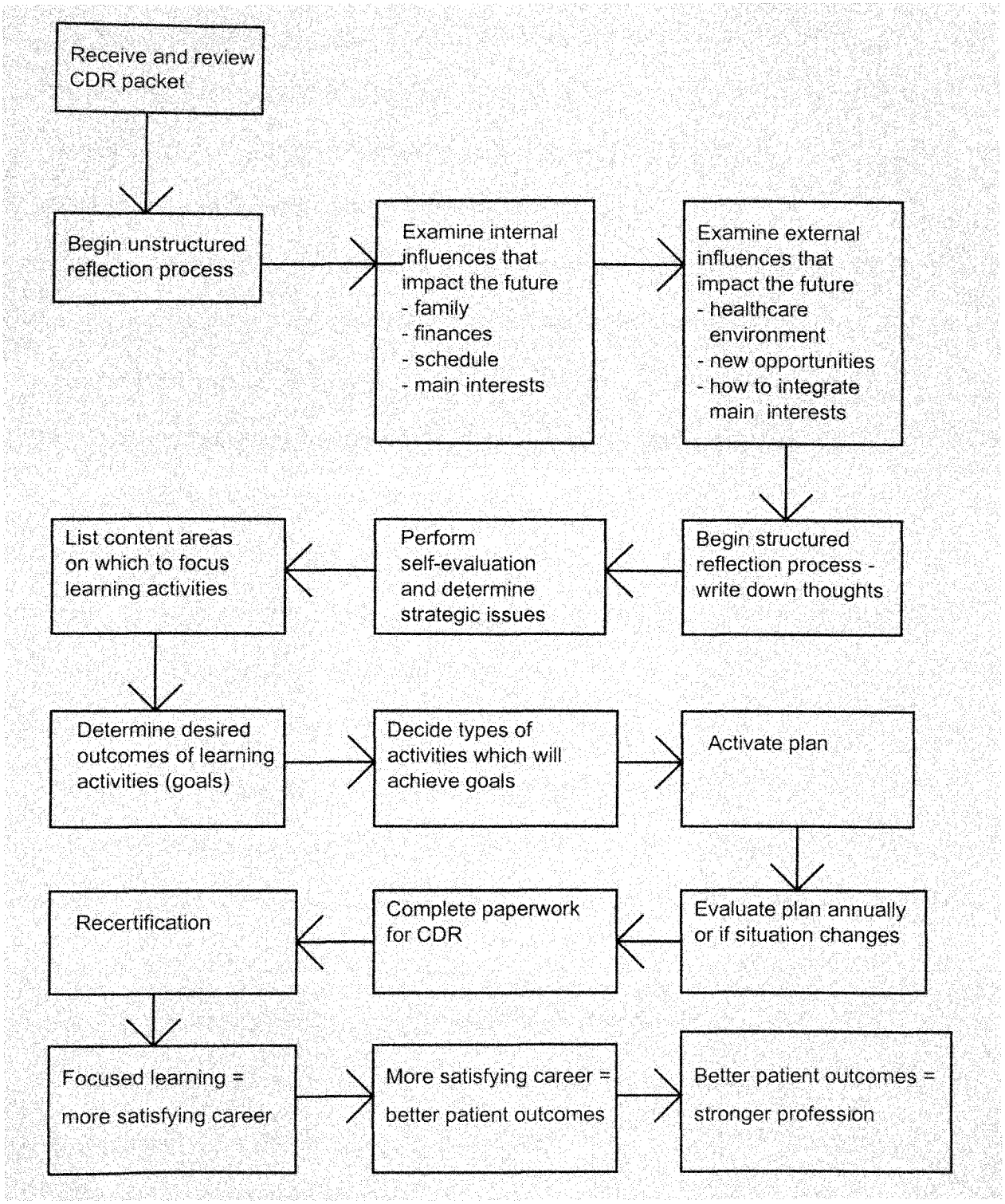


Figure 2. Revised process model for goal setting

the job of the RD will be done better and therefore, have more value. The final beneficiary is the profession in general. Dietetics will be raised to a new level of value and respect if each RD in practice becomes an example of the focused, targeted, up-to-date practitioner that *PD 2001* seeks to create.

Goal setting will be a critical step in the new recertification program and this process model delineates the steps a practitioner should take to arrive at his or her goals. For the practitioners in the focus groups, reflection is an on-going process of thought and evaluation rather than a scheduled activity. Since most practitioners reported engaging in unstructured reflection, this became the first part of the process model. To be effective the reflection must take into account the real constraints of family, money, geography, schedule, and the practitioners main interests. These are the internal influences that were most often discussed by the focus group participants.

The next step of the model is to examine the external influences or the matters that are outside of personal control. These include the changing healthcare environment, new opportunities that are evolving for dietitians as healthcare changes, and the practical ways to integrate personal interests into the individual situation that forms each practitioner's world. The participants stated that their goals might be different in an ideal situation but that they all were limited by various personal and societal factors.

The next step is to perform the structured reflection. The practitioner should begin writing down his or her thoughts and ideas including likes and dislikes about the profession, personal goals, abilities and weaknesses, and constraints.

This will lead to the next step, which is the formal self-evaluation. It is during this step that the practitioner will begin to uncover his or her strategic issues. The strategic

issues are the critical issues that take precedence over the less-important items uncovered during reflection. For example, a practitioner may have a desire for a certain schedule due to a child's school schedule and may also identify a passion and ability for pediatric nutrition. The practitioner knows that the pediatric dietitian usually must work the 7:00 AM shift because that is when the babies are fed. Unfortunately, that doesn't coordinate with the school schedule of the RD's child so the strategic issue is the schedule and that would take precedence over the desire for the pediatric dietitian position. Each individual will have different strategic issues that will come to the forefront if reflection and self-evaluation are performed adequately.

Once the self-evaluation is complete, the practitioner should be able to identify goals for the five-year credentialing cycle. The next step is to begin listing content areas on which the learning activities will be focused. The outcomes of these activities should be determined next and what activities will help achieve those outcomes. For example, if the practitioner decides to obtain a graduate degree or a certification, the learning activities should be focused on that. If the desired goal is to obtain a certain level of proficiency, the proper activities should be selected to meet that outcome. In addition, unless the goals are pertinent to their passions and interests, the motivation may not be high enough to accomplish the goal. Participants echoed what was reported by Tassone and Speechley (31). Easily accessible and affordable learning activities are most preferred and accepted when CE is required. It will be crucial to have proper activities accessible when practitioners arrive at the point of identifying learning activities that will help them meet their learning needs. Technology may help bring quality CE programs to the more remote areas of the country but dietitians will first need to learn this technology

and feel comfortable with accessing information in this manner. Brandt, Sapp, and Campbell (16) had the same conclusion with health sciences librarians. Unless dietitians become familiar with technologically advanced methods of delivery, the desired type and level of learning activity may be difficult to find. The need for learning about technology will most likely become a goal of practitioners particularly in the first several years of *PD 2001*.

The next step is to activate the plan. This will consist of several years of attending learning activities and evaluating if the activity has helped the practitioner make progress toward the goals. If the goals change due to job change or a change in the practitioner's personal life, the process should be repeated accordingly. At the end of the five-year cycle, the practitioner will complete the necessary paperwork and submit it to CDR and recertification will be provided.

The initial process model (Figure 1, page 46) showed individual practitioners, patients, and the profession on the same level as beneficiaries. The focus group discussion clarified the preliminary model by showing a progression of benefits. The focus group discussions indicated that the participants believed that the process of focused learning would help them have a more satisfying career. They identified the individual practitioner as the first beneficiary. The patients were identified as the second beneficiaries since they would receive better care and hopefully, have better outcomes. The third tier of benefits was believed to be a stronger profession as a whole.

Since most participants did not set goals for themselves unless mandated by an employer's performance appraisal, this process will be a new experience. It will be critical to the success of the new program to provide assistance to practitioners. Most of

the information reported as fact by focus groups participants was gathered from speaking with colleagues and through the informal channels of communication. The very first group to undergo the new process in 2001 will set the tone for those that follow. The experiences of this group will filter down to the next group through the informal channels of communication. This makes it even more important that proper steps are taken while there is time to insure the success of the new program particularly for those nearing retirement.

Queeney and English (22) discuss participants' readiness to learn. Their belief is that if learners take responsibility for their own learning, they will select activities that benefit them. This theory applies to practitioners at any stage of their career. Since those dietitians close to retirement voiced concerns about the applicability of the new program at their career stage, it may be helpful to highlight the self-responsibility aspect of *PD 2001* in the CDR materials. Queeney and English also say that a criterion for quality CE programs is relevance to practice. Those nearing retirement may not have new goals or goals for advancement but may only want to stay current in their area of practice. The findings from the focus groups show that participants did not feel that merely staying current would be an acceptable goal. Since nutrition is a rapidly changing field, it is appropriate to have learning focused on staying abreast of new developments. This would make the information more pertinent and therefore, more useful to the practitioner.

The word "goal" seemed to connote a large step or a certain activity to most participants. The most common example cited as a goal was obtaining a Master's degree. Most participants wanted a concrete outcome such as the receipt of a degree to confirm that they had indeed reached their goal. The idea that a practitioner could have several

small goals in several different areas of the profession did not come easily to the participants. The notion of self-evaluation to determine progress towards goals was equally as troubling. The participants were hesitant to accept the fact they had the skill to decide if they were sufficiently competent to practice in their job setting. This may be related to the fact that most practitioners work in highly regulated environments with JCAHO overseeing hospitals and HCFA regulating nursing homes. The idea that each practitioner will design and monitor his/her own plan is quite the opposite of most dietitian's work environment.

A repeated discussion in every state was exactly who is the intended beneficiary for the new program. All groups were asked to consider benefits on three levels – the individual practitioner, the patient or client, and the profession as a whole. Many participants did not see any beneficiary at all until forced to think about it. When it was explained that the ultimate goal is to insure competency of dietetic practitioners, the participants wondered how self-evaluation could insure competency. This relates to the work of von Rennan (35) who studied portfolio models of competency in health sciences librarians. The competency increased when the circle of learning was complete with a behavior change and a plan to transfer didactic learning into practice settings. This part of the cycle has never been required of dietitians. Under the old system, once participants had a certificate of attendance at a CE program, they had completed the activity. The new system will require an evaluation of the learning experience, which begins to complete the circle. This requirement was not understood by the focus group participants and may help them to understand how the portfolio will reflect their progress

towards goals. The link between better prepared practitioners and better care for patients was not clearly drawn by the CDR information received by focus group participants.

# CHAPTER V

# SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

## Summary

In the year 2001, CDR will begin recertifying dietitians using a self-directed lifelong learning portfolio model entitled *Professional Development 2001* (*PD 2001*). This portfolio consists of five steps. The steps are reflection, learning needs assessment, formulation of a learning plan, maintenance of a learning log and finally, evaluation of the learning plan. The impetus for change from the current system of requiring a quantity of 75 continuing education (CE) hours to the new system of targeted learning is the issue of competency. Competency has become an important issue in healthcare as more attention is paid to this issue by regulatory agencies and customers alike. The purpose of this study was to identify the methods dietitians use to determine their five-year goals and direction in practice. It was also to determine their attitudes towards *PD 2001* and identify some of the factors that influenced and shaped their beliefs.

Sixteen focus groups were held in conjunction with state dietetic association affiliate meetings. Each focus group had seven to ten Registered Dietitians as participants for a total of 132 participants. The focus group participants were required to complete a questionnaire prior to the focus group discussion in order to obtain demographic data and construct a profile of the participants. From this questionnaire it was determined that participants represented the general membership of ADA in regards to area of practice with 65 percent in either the clinical or food and nutrition management areas. The remainder of the participants worked in educating future practitioners or was unemployed due to childrearing. The participants had between six months to 48 years of experience.

The mean number of years of practice was 13.4 ± 7.8 years. Seventy-seven percent of the participants had dietetics as their first and only career. The focus group participants were asked a series of questions about how they determine their career paths and goals and about their attitudes towards *PD 2001*. The groups were audio-taped with informed consent. The tapes were transcribed into 643 pages of text and analyzed using Non-numerical Unstructured Data - Indexing Searching and Theorizing (NUD*IST version 4).

Thirty-four of the 132 participants (26%) had formal five-year goals. Fifty–four participants (41%) performed annual self-assessments. Most often these assessments were required as part of a job performance appraisal. The majority did not currently have professional goals nor perform self-assessments. Establishing goals and conducting self-assessments will be new activities for most participants. The majority of the participants felt that they were uncomfortable with the idea of goal setting and had not been trained in how to formulate goals. There was concern that the paperwork required by *PD 2001* would be time-consuming and difficult to complete. Other fears included the possibility of having learning plans rejected and not being able to achieve their goals due to changing circumstances. Many fears were based on misinformation. Exactly half of the participants had attended delegate sessions on the topic of *PD 2001* while the other half did not. Participants who held leadership positions in their district or state affiliate had a more accepting attitude of the new requirements.

**Conclusions**

The following conclusions relate to the sample of Registered Dietitians studied in the eight states. It is recognized that these dietitians attended a state professional meeting and volunteered to participate in a focus group setting. However, the representation of

areas of practice and the variety of opinions voiced provide confidence that this sample contains many elements similar to the profession at large.

There appeared to be a lack of communication between CDR, representing the professional association, and its members. CDR is readying itself for a major change in the credentialing process while the practitioners it regulates appear ill-prepared to make this paradigm shift. Dietitians, as a rule, did not practice five-year goal setting and lacked the skill for this process. Further, other professional development activities like formal self-assessment were not conducted unless a self-assessment was required as part of an annual performance appraisal. As a result, dietitians in the management area of practice were more likely to engage in annual self-assessments. Self-assessment and reflection seemed to be mainly an informal non-structured process.

If professional development was to be used to prepare for a new job, increase current job skills, or expand job responsibilities, then certain aspects of career choices would be the most important: pay, work schedule, the opportunity to be self-directed, the opportunity to apply technical expertise, and a variety of job duties.

Misinformation about the requirements of *PD 2001* caused negative attitudes towards it. The participants often confused the different drafts of *PD 2001* and this added to their confusion. Exactly one-half of participants attended formal sessions on *PD 2001*; quality of the formal sessions on *PD 2001* varied from location to location. Active members of local and state dietetic associations had the most accepting attitude towards *PD 2001*. Area of practice (management, community, education, clinical) of the dietitians did not seem to influence attitude towards *PD 2001,* but those in management were somewhat less fearful of the goal setting process. However, number of years in practice did

influence the attitude towards *PD 2001* with those nearing retirement voicing serious concerns.

Generally, most participants were resigned to the program but failed to see a clear benefit of the change. Most rationalized that they would get used to the new program with time and lack of another alternative but did not see this as a panacea for the problems in the profession. Participants welcomed opportunities such as these focus groups to voice their concerns and clarify misconceptions.

**Recommendations**

This research has provided answers to several questions never before addressed in the dietetics profession. The broad geographical areas covered and the in-depth responses from focus groups are replete with issues for further study. This study has clearly taken professional goal-setting related to the credentialing process of dietitians to the next level. Therefore, recommendations based on the information discovered by this study, fall into two categories: those for CDR and those for future researchers.

In order for *PD 2001* to have a successful implementation, the following recommendations are made to CDR:

1. Written materials should be revised and sent to all certificants outlining the final rules and implementation process. These materials should clearly delineate the reason for the change from the old system and the perceived benefits of the new system. Different materials should be developed for the three age categories identified by this study – those in their first five-year credentialing period, those with six to nineteen years of practice, and those with greater than twenty years of practice. The materials directed at entry-level

practitioners should be different than those for dietitians nearing retirement since each of these groups has a different perspective.

2. A training session for speakers and delegates should be held to fully explain the final draft of *PD 2001* and assure consistency and enthusiasm among the presenters. The speakers must possess an understanding of the philosophy and all components of *PD 2001*. Only supporters who believe in the system should be utilized as speakers.

3. Skills workshops should be scheduled in conjunction with state and district affiliate meetings to teach goal setting techniques and self-assessment processes. These workshops should be small groups of dietitians with a well-trained instructor. The cost should be affordable and the location should be easily accessible. Teleconferences, online versions, and other technology should be utilized to make this available to all practitioners.

4. A rumor control hotline should be established to answer questions that arise from practitioners. Many focus group participants were asking their peers for answers to their questions rather than going to an accurate source for information. A rumor control hotline would assist in assuring that correct information is disseminated.

5. Entrepreneurial dietitians should be encouraged to develop content-specific self-assessments, tools, and workshops to assist with the *PD 2001* process. Guidelines should be developed by CDR to guide the development process. All programs that meet CDR requirements would advertise as being "CDR-approved."

6. Educational curriculums for entry-level dietitians should be encouraged to include goal setting skills, portfolio development, and self-assessment as course requirements as soon as possible.

Credentialing systems do not often undergo such a major change. This change presents researchers with the unique opportunity to study the implementation process and the results. The following recommendations are made to future researchers:

1. Future studies should monitor for a change in competency level and the advancement of the profession once all dietitians are certified using the new system. These studies may focus on the methods used to construct portfolios, the methods of self-evaluation, the transfer of learning into practice, the shift in attitudes, and the ethical implications of self-reported learning.

2. The impact of the portfolio method of credentialing on state licensure should be researched carefully. Many states will continue their requirements for approved CE hours even after *PD 2001* has begun. This may mean that many practitioners must maintain two learning logs – one for their professional credential and one for their state license. Future studies should monitor the meshing of the two systems and the manner in which these issues are handled.

3. The phased implementation of *PD 2001* lends itself to many studies. The first group to begin the process in 2001 can be monitored and compared to the middle group in 2003 and the final group in 2006 for the issues described above.

4. The year 2011 will mark the ten-year anniversary of *PD 2001*. A major study assessing the state of the profession at that point in time should be done to evaluate the success or failure of *PD 2001*. If *PD 2001* has not met expectations, modifications or an entirely new system can be developed.

5. If focus groups are the chosen methodology to obtain qualitative data, the focus

group moderator should be well-trained and prepared in focus group techniques. Preliminary or trial groups should be conducted to test the focus group questions and give experience in moderating these groups.

6. Questionnaire data is recommended as a method to collect quantitative data to enhance the qualitative data.

7. Scheduling data collection during annual dietetic association meetings is recommended as a way to obtain a wide-variety of participants in an economical manner.

## References


1. Maw JA, Sleezer CM. Multiskilling: the quiet revolution in healthcare education and training. *J Hlth Occ Ed.* 1995;10:39-53.

2. Dahl L, Leonberg B. JCAHO and CDR: meeting the competence challenge. *JADA.* 1998;98:589-590.

3. Jensen GM, Saylor C. Portfolios and professional development in the health professions. *Eval & Hlth Prof.* 1994;17:344-357.

4. Schatz IJ. Changes in undergraduate medical education. *Arch Intern Med.* 1993;153:1045-1051.

5. Inman-Felton A, Rops MS. *Ensuring Staff Competence.* Chicago, IL: American Dietetic Association; 1998.

6. Woodard NM. Dietetics credentialing: past, present, and future. *Challenging the Future of Dietetic Education and Credentialing.* Future Search Conference Proceedings. June 12-14, 1994.

7. Casell JA. *Carry the Flame: The History of The American Dietetic Association.* Chicago, IL: American Dietetic Association; 1990.

8. Winterfeldt EA, Bogle ML, Ebro LL. *Dietetics - Practice and Future Trends.* Gaithersburg, MD: Aspen Publishers, Inc.; 1998.

9. Stromberg CD. *Healthcare Credentialing: Implications for Academic Health Centers.* Washington, DC: Association of Academic Health Centers; 1992.

10. *Laws That Regulate Dietitians/Nutritionists.* The American Dietetic Association State Affiliate Legislative Chairperson information packet; 1997.

11. Berman SJ, Perkocha VA, Novotny TE. A continuing education preference survey of public health graduates. *Am J Prev Med.* 1995;11:19-25.

12. Commission on Dietetic Registration. *Professional Development Portfolio Guide.* Chicago, Ill: American Dietetic Association; 1998.

13. Kelly C, Cowell JM, Stevens R. Surveying public health nurses' continuing education needs: collaboration of practice and academia. *J Cont Ed Nrsg.* 1997;28:115-123.

14. Puckett RP. Education and the dietetics profession. *J Am Diet Assoc.* 1997;97:252-253.

15. Hammonds BL. New content-specific continuing education requirements. *Am J Health-Sys Pharm.* 1996;53:997-998.

16. Brandt KA, Sapp JR, Campbell JM. Current topics in health sciences librarianship: a pilot program for network-based lifelong learning. *Bull Med Libr Assoc.* 1996;84:515-523.

17. Gates EA. New surgical procedures: can our patients benefit while we learn? *Am J Obstet Gynecol.* 1997;176:1293-1299.

18. Kreszock M. A holistic look at professional development. *North Carolina Libraries.* 1997;55:7-11.

19. Maslin-Prothero SE. A perspective on lifelong learning and its implications for nurses. *Nurse Education Today.* 1997; 17:431-436.

20. Knapper CK, Cropley AJ. *Lifelong Learning and Higher Eucation.* London: Kogan Page; 1991.

21. Bronte L. Learning to change. *Adult Learning.* 1997; May/June:11-13.

22. Queeney DS, English JK. *Mandatory Continuing Education: A Status Report.* Columbus, Ohio: ERIC Clearinghouse on Adult, Career, and Vocational Education; 1994.

23. Dowd SB. Mandatory CE - time to move on? *Rad Tech.* 1995;66:393-395.

24. Kane MT, Cohen AS, Smith ER, Lewis C, Reidy C. *1995* Commission on Dietetic Registration Dietetics Practice Audit. *J AM Diet Assoc.* 1996;96:1292-1301.

25. Houle CO. *Continuing Learning in the Professions.* San Francisco, CA: Jossey-Bass Publishers; 1980.

26. Affara F. Why lifelong learning? *Int Nurs Rev.* 1997;44:177-180.

27. Verma M, Singh T. Continuing education: concepts and strategies. *J Ind Acad Ped.* 1995;32:557-563.

28. Oeschle L, Volden C, Lambeth S. Portfolios and RNs: an evaluation. *J Nrsg Ed.* 1990;29:54-59.

29. Jensen GM, Saylor C. Portfolios and professional development in the health professions. *Eval & Hlth Prof.* 1994;17:344-357.

30. Maslin-Prothero SE. A perspective on lifelong learning and its implications for nurses. *Nurse Education Today.* 1997; 17:431-436.

31. Tassone MR, Speechley M. Geographical challenges for physical therapy continuing education: preferences and influences. *Phys Ther.* 1997;77:285-295.

32. Belanger P, Valdivielso S. *The Emergence of Learning Societies: Who Participates in Adult Learning?* Great Britain: Galliard Ltd; 1997.

33. Klevans DR, Parrett JL. Continuing professional edcuation needs of clinical dietitians in Pennsylvania. *J Am Diet Assoc.* 1990;90:282-286.

34. Dahl L. Selected models: portfolio model. *Continued Competency Summit. Course Materials: A Compendium of Conference Handouts.* July 25 - 26, 1997.

35. von Reenan JA. The transfer of learning from continuing education to the job. *Bull Med Libr Assoc.* 1996;84:257-260.

36. Barnhill GC. Continuing competency: selected models. *Continued Competency Summit. Course Materials: A Compendium of Conference Handouts.* July 25 - 26, 1997.

37. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals.* JCAHO; Oakbrook Terrace, IL: 1996.

38. Inman-Felton A, Rops MS. *Ensuring Staff Competence.* Chicago, IL: American Dietetic Association; 1998.

39. Mullan F, Politzer RM, Lewis CT, Bastacky S, Rodack J, Harmon RG. The national practitioner data bank. *JAMA.* 1992;268:73-79.

40. Stromberg CD. *Healthcare Credentialing: Implications for Academic Health Centers.* Washington, DC: Association of Academic Health Centers; 1992.

41. Commission on Dietetic Registration. *Professional Development 2001: Guide to the Proposed Recertification System.* Chicago, Ill: American Dietetic Association; 1997.

42. Trenker LL, Achterberg CL. Use of focus groups in evaluating nutrition education materials. *J Am Diet Assoc.* 1991;91:1577-1581.

43. International Food Information Council. Focus on qualitative research. *Food Insight.* 1997;May/June:1-4.

44. Connaway LS. Focus group interviews: a data collection methodology for decision making. *Library Admin Mgt.* 1996;10:231-239.

45. Creswell JW. *Research Design: Qualitative & Quantitative Approaches.* Thousand Oaks; Sage Publications: 1994.

46. Bailey CA. *Field Research.* Thousand Oaks; CA: Pines Forge Press: 1996.

47. Morse JM, Field PA. *Qualitative Research Methods For Health Professionals.* 2nd ed. Thousand Oaks, CA; Sage Publications: 1995.

48. Morgan DL. *Focus Groups as Qualitative Research.* Newbury Park, CA; Sage Publications: 1988.

49. Betts NM, Baranowski T, Hoerr SL. Recommendations for planning and reporting focus group research. *J Nutr Ed.* 1996;28:279-281.

50. Krueger RA. *Focus Groups.* 2nd ed. Thousand Oaks; Sage Publications: 1994.

51. McCarthy PR, Lansing D, Hartman TJ, Himes JH. What works for worksite cholesterol education? Answers from targeted focus groups. *J Am Diet Assoc.* 1992;92:978-981.

52. Berg BL. *Qualitative Research Methods for the Social Sciences.* Boston: Allyn and Bacon: 1998.

53. Morse JM, Field PA. *Qualitative Research Methods for the Health Professional.* Thousand Oaks, CA: Sage Publications; 1995.

54. Isaac S, Michael WB. *Handbook in Research and Evaluation.* San Diego, CA: Edits Publishing;1977.

55. Bryk JA, Soto TK. Report on the 1997 membership database of the American Dietetic Association. *J Am Diet Assoc.* 1999;99:102-107.

# APPENDICES

# APPENDIX A

# AFFILIATE LETTER

July 1, 1998

(State Affiliate)
(Contact Name)
(Affiliate Address)

Dear _____,

The new Commission on Dietetic Registration (CDR) recertification process for dietitians and technicians will effect us in 2001. As the implementation of this new process nears, we want to hear your members' questions and concerns about how this will impact their continuing education plans and maintenance of their registration status. We are working in conjunction with CDR to speak to members across the country about these concerns and member expectations. We would like to offer your members the opportunity to participate in these forums.

The discussions will be in the form of two one-hour focus groups held in conjunction with your annual meeting. The focus groups will be part of a national study on this topic. Each focus group is limited to ten participants and will be led by Nancy Collins, MS, RD, LD. You may invite state leaders to participate or ask for volunteers on a first-come basis. We have found that we must limit these groups for accurate recording of responses. However, a presentation to your general membership can be arranged using CDR's slide presentation on *Professional Development 2001*. Nancy has experience speaking to large groups of physicians and dietitians and her enthusiasm for this topic has been well-received by Florida dietitians.

The cost to you will be minimal considering the opportunity for further discussion of this important topic. There is no speaker honorarium or fee. However, we do request that Nancy's travel expenses be paid by the affiliate association.

If this is a session you would like to include as part of your annual meeting program, please contact Nancy Collins at 954-438-4002 or via e-mail at NCtheRD@aol.com.

Sincerely,

Susan P. Himburg, PhD, RD, LD, FADA  Dian Weddle, PhD, RD, FADA

Nancy Collins, MS, RD, LD/N

# APPENDIX B

# INFORMED CONSENT

# Informed Consent

**Methods Dietitians Use For Constructing Five Year Goals and Attitudes Towards *Professional Development 2001***

I freely and voluntarily consent to participate in the research project entitled *Methods Dietitians Use For Constructing Five Year Goals and Attitudes Towards Professional Development 2001* to be conducted by Florida International University during 1999, with Nancy Collins, MS, RD, LD/N as Principal Investigator. I have been told that this focus group will last approximately sixty minutes. I have been told that this focus group will be audio-recorded for the purpose of transcription and that names of participants will not be released or published.

I understand that the purpose of this research is to identify the methods dietitians use to determine five year goals and direction in practice. The secondary purpose is to identify attitudes toward *Professional Development 2001* (*PD 2001*) and determine what factors influence and shape dietitians' beliefs.

I understand that there are no known risks or benefits involved in my participation in this focus group.

I understand that I may withdraw my consent and discontinue participation in this research project at any time with no negative consequences. I have been given the right to ask questions about this project and any questions have been answered to my satisfaction.

I understand that if I desire further information about this research I should contact Nancy Collins, MS, RD, LD/N, Dr. Susan Himburg, RD, FADA, or Dr. Dian Weddle, RD, FADA at 305-348-2878. I have been offered a copy of this informed consent form.

I have read and I understand the above.

_____ _____

Participant's Signature Date

I have explained and defined in detail the focus group procedure in which the participant has agreed to participate and have offered him/her a copy of this informed consent form.

_____ _____

Principal Investigator's Signature Date

# APPENDIX C

# QUESTIONNAIRE

# Methods Dietitians Use For Constructing Five Year Goals And Attitudes Towards *Professional Development 2001*

1. How many years have you been a credentialed dietitian? _____

2. Which of the following best describes your career in dietetics?

_____ Dietetics has been my first and only career

_____ I switched to a career in dietetics after working in another profession

3. Which area of dietetics do you work in? Check the one that best describes the majority of your job responsibilities.

_____ Clinical _____ Management

_____ Community _____ Education of dietetic practitioners

4. What is your job title? _____

5. Circle the number that best describes your level of involvement and activity in your district and/or state dietetic association?

Not Involved Actively Involved

**1 2 3 4 5**

6. Have you attended any lectures and/or delegate reports on *Professional Development 2001*?

_____ Yes _____ No

7. Did you find the lecture and/or delegate report helpful and informative?

Not helpful Very Helpful

**1 2 3 4 5**

8. Have you read the CDR materials mailed to you on *PD 2001*?

No Skimmed Read Thoroughly

**1 2 3 4 5**

9. Did you find the CDR materials helpful and informative?

Not helpful Very Helpful

**1 2 3 4 5**

10. Have you worked with requirements similar to *PD 2001* or a similar model in the past?

_____ Yes _____ No

11. Do you have formal professional five year goals?

_____ Yes _____ No

12. If you have five year goals, what process or tools did you use to formulate those goals?

_____ Performance appraisals

_____ Journals or practice group material

_____ ADA Self-Assessment series

_____ Guidance from a mentor

_____ Others - Please specify _____

_____

_____

13. Do you perform annual professional self-assessments?

_____ Yes _____ No

14. For each of the factors listed below, circle the number that best describes the importance of that factor in determining your future career direction.

A. **Schedule**

| Not important | | | | Very Important |
|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** |

B. **Pay**

| Not important | | | | Very Important |
|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** |

C. **The opportunity to be self-directed and make independent decisions**

| Not important | | | | Very Important |
|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** |

D. **The opportunity to apply technical expertise**

| Not important | | | | Very Important |
|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** |

E. **The variety of job duties**

| Not important | | | | Very Important |
|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** |

15. What impact do you think *PD 2001* will have on the profession of dietetics?

# APPENDIX D

# FOCUS GROUP PROTOCOL

## Focus Group Protocol

| | |
|---|---|
| Session length: | One hour. |
| Setting: | Affiliate dietetic association annual meeting. |
| Set-up: | Private room with a round table to seat 11 participants. Each room equipped with access to an electrical outlet, an extension cord if needed, pens, and a water pitcher. |
| Security: | Volunteer required to be present at each focus group to monitor the door and assure no interruptions, disturbances, and handle any logistical occurrences such as the room being too cold or too hot. |
| Equipment: | Tape recorder with two in-line microphones to be placed at opposite sides of the table. |
| Participant Criteria: | Registered Dietitian status, currently credentialed by the Commission on Dietetic Registration, agreeable to complete questionnaire, and willing to discuss the topic of *Professional Development 2001 (PD 2001)*. |
| Participant Selection: | Consistent procedures followed at each setting to limit to a maximum of ten participants.<br>1. Promotion of focus groups in pre-convention materials.<br>2. Access to volunteer sign-up sheet prior to meeting. |
| Activity Time-Line Prior to Meeting: | 9 months – Send letter to affiliate to solicit participation (App. A).<br>6 months – Confirm participation with affiliate by telephone. Verify procedures for recruiting volunteers. Send focus group objectives and planned content outline.<br>2 months – Arrange flight and hotel reservations.<br>2 weeks – Reconfirm all arrangements. Copy questionnaires. Test tape recording equipment.<br>On location – Check room arrangements. Verify availability of "security" volunteer. Obtain participant sign-up sheet. |
| Guiding questions: | The following questions were used to guide the focus groups and asked at all 16 focus groups:<br>1. What do you understand is the purpose of *PD 2001*?<br>2. What do you understand are the requirements of *PD 2001*?<br>3. Step one is Professional Self-Reflection. How do you "reflect" on your career and set your goals?<br>4. How do you think dietitians should go about setting five-year goals? |

5. How do you think *PD 2001* will affect the dietetics profession?
6. How do you think *PD 2001* will affect you as an individual practitioner?

# APPENDIX E

# FOCUS GROUP LOGS

## Focus Group Logs

| Date | City, State | Venue | Time | n |
|---|---|---|---|---|
| Mar. 2, 1999 | Oklahoma City, OK | Zoo Education Center | 1:00 PM | 9 |
| Mar. 3, 1999 | Oklahoma City, OK | Zoo Education Center | 9:00 AM | 7 |
| Apr. 9, 1999 | Houston, TX | JW Marriott Hotel | 11:30 AM | 10 |
| Apr. 10, 1999 | Houston, TX | JW Marriott Hotel | 12:30 PM | 9 |
| Apr. 13, 1999 | Indianapolis, IN | Marriott Hotel | 2:00 PM | 7 |
| Apr. 14, 1999 | Indianapolis, IN | Marriott Hotel | 7:00 AM | 7 |
| Apr. 15, 1999 | Springfield, MO | University Plaza Hotel | 11:00 AM | 10 |
| Apr. 16, 1999 | Springfield, MO | University Plaza Hotel | 12:00 PM | 8 |
| Apr. 23, 1999 | Bloomington, MN | Marriott Hotel | 10:30 AM | 8 |
| Apr. 24, 1999 | Bloomington, MN | Marriott Hotel | 1:00 PM | 8 |
| May 2, 1999 | Clemson, SC | Martin Inn | 5:30 PM | 8 |
| May 3, 1999 | Clemson, SC | Martin Inn | 7:00 AM | 9 |
| Jun. 10, 1999 | Woodbridge, NJ | Sheraton Hotel | 11:45AM | 10 |
| Jun. 11, 1999 | Woodbridge, NJ | Sheraton Hotel | 4:00 PM | 8 |
| Jun. 22, 1999 | Greensboro, NC | Holiday Inn | 1:00 PM | 7 |
| Jun. 23, 1999 | Greensboro, NC | Holiday Inn | 10:00 AM | 7 |

# VITA

## NANCY COLLINS

| | |
|---|---|
| 1986 | B.S., Hotel/Foodservice Administration<br>University of Nevada, Las Vegas<br>Las Vegas, Nevada |
| 1991 | M.S., Dietetics and Nutrition<br>Florida International University<br>Miami, Florida |
| 1991- Present | Consultant Dietitian<br>Private Practice<br>Pembroke Pines, Florida |
| 1994 - 1998 | Adjunct Instructor<br>Florida International University<br>Miami, Florida |